Occupational Therapy

A COMMUNICATION PROCESS IN PSYCHIATRY

A COMMUNICATION PROCESS
IN PSYCHIATRY

Occupational Therapy

GAIL S. FIDLER, O.T.R.
JAY W. FIDLER, M.D.

The Macmillan Company, New York
Collier-Macmillan Limited, London

First Printing, May, 1963

Earlier edition: *Introduction to Psychiatric Occupational Therapy*, copyright, 1954, The Macmillan Company

Library of Congress catalog card number: 63-11792

THE MACMILLAN COMPANY, NEW YORK
COLLIER-MACMILLAN CANADA, LTD., TORONTO, ONTARIO

Printed in the United States of America

Preface

That activities for the psychiatric patient can be beneficial has long been known and has been demonstrated repeatedly throughout the centuries. How the activities achieve the desired benefit remains largely unexplained. The task of relating the psychopathology of the patient to the mechanisms whereby the activities alter that pathology remains largely unsurmounted.

To understand the nature and extent of the problem requires a view of the fields of psychiatry and psychopathology to which occupational therapy must relate itself. The number and variety and parochial character of the "schools of psychoanalytic thought," to say nothing of the variety of nonanalytic concepts of psychopathology, pose one problem. Each different school understands the process of change in a somewhat different manner. As a consequence, no specific statement about occupational therapy will have the same meaning for all these groups. The problem can be additionally compounded when it is recognized that, "in the field," occupational therapy is often requested by administrative personnel or physicians for reasons with a most tenuous relationship to any concepts of psychopathology.

We face then several alternatives. We can single out one "school of thought" and attempt to indicate working concepts that will allow for or encourage the use of activities in the therapeutic planning of adherents of that school. We can attempt to formulate a self-contained theory of psychopathology with its own diagnostic criteria and therapeutic planning with productive activity as its central theme. This would, in effect, be adding another school to the list. There is also the possibility of trying to elucidate the characteristics of activity and to identify enough components so that the proponents of any school can then com-

prehend what is involved and translate this into useful planning within their own theoretic framework.

Our goal is the last of these. However, in the process of elucidating the characteristics of an activity, we will necessarily have to state our observations as we see them through eyes conditioned by our own theoretic framework. Hopefully, this should be understandable in the psychiatric native tongue of the reader with not too much difficulty.

We feel that treatment in psychiatry cannot be fully understood without knowledge of the role and function of the therapist as well as of the therapeutic modality employed. Treatment is the product of a therapeutic dyad, with different professions using different modes of interaction with the patient. The occupational therapist may be seen as the technician who proffers materials and know-how to permit the patient to be occupied. He may also be seen as a person with whom the patient forms a relationship, so that interactions not directly pertinent to the activity or object will influence his welfare. He may be expected to know psychopathology and make his judgments about therapy independently. Or he may be expected to follow the line of reasoning of the psychiatrist and suggest ways in which he can promote these therapeutic objectives.

Psychiatric occupational therapy may be viewed as a specific technique with specific benefits and specific limitations comparable, for instance, to electroconvulsive therapy. On the other hand, it may be viewed as a largely nonverbal form of discourse comparable to but qualitatively different from interview psychotherapy. It may be seen as the manipulation of object relationships and classed as parallel to but separate from verbal relationships.

Our expectation is that, as various therapists perceive a patient's problems in different ways, they will also see the therapeutic tools, among them occupational therapy, in various perspectives. These different perspectives can be accommodated in interview psychotherapy by the appropriate change of manner, technique, and subject matter. Occupational therapy is in effect another language for communication with the patient, and this

language too can accommodate various perspectives. It is our intention to convey some of the characteristics of this language and some of the reasoning whereby it can be applied. If our goal is achieved, we should be able to plan the psychologic therapy of patients with purposeful use of activities and of the interpersonal field in which they are employed, just as we can direct the use of ventilation, abreaction, or the interpretation of transference in the interpersonal field of the interview.

Whoever is called on to plan this phase of treatment of a patient, whether psychiatrist or occupational therapist, should know something of the characteristics of the activities available, something of the characteristics of the particular therapist involved, and something of the characteristics of the group interaction of the other patients sharing this experience. Each of these parameters of the occupational therapy situation has its impact on the patient, and at times one may be of transcendent importance whereas another may pre-empt the field later.

Finally, we view occupational therapy as simply a part of any comprehensive treatment program rather than as the whole of treatment. This forces us to face the problem of staff communication and coordination. Concern for morale and the self-esteem of the individual therapist on the team helps each to contribute his best. A shared fund of knowledge, so that the concerns and objectives of other members can be understood, will improve chances for fruitful communication and coordination. The red tape of record keeping and administrative activities must also be considered.

Awareness of each of these factors should provide a reasonable perspective on the potentials and the limitations of psychiatric occupational therapy and shed some rational light in an area where empiric observations have been the prime illumination for many centuries.

GAIL S. FIDLER, O.T.R.
JAY W. FIDLER, M.D.

Acknowledgments

The set of concepts formulated while working in a profession always derives from many persons and many sources. The assistance of each cannot always be identified, and the contributor may not always recognize his own contribution. Some individuals, however, have played specific roles in helping us toward our formulations.

Dr. Nathaniel S. Apter's recognition of the therapeutic potential in activities gave us our first appreciation of the dynamic features of the occupational therapy situation. Dr. Elvin V. Semrad provided encouragement and guidance in further exploring and clarifying our formulations. Elizabeth P. Ridgway, O.T.R., has over the years contributed a perceptive understanding and a capacity for creative analysis that have enriched our learning and contributed immeasurably to the development of our concepts. Susan B. Fine, O.T.R., with wisdom and skill has offered courage and vision in the testing and elaboration of our concepts. There have been many students and staff members who, in their desire to improve service to patients, have offered ideas and worked with us toward clarification.

We wish to acknowledge the *American Journal of Occupational Therapy* for allowing us to reprint material from "Some Unique Contributions of Occupational Therapy in the Treatment of the Schizophrenic," by Gail S. Fidler, Vol. 12, No. 1, 1958.

Finally, we are deeply indebted to Mrs. Elsie Durkin for typing the manuscript and certainly to Beryl for holding the family together during these trying months.

GAIL S. FIDLER, O.T.R.
JAY W. FIDLER, M.D.

To

DAGNY and ERIC

Table of Contents

Occupational Therapy

A COMMUNICATION PROCESS IN PSYCHIATRY

CHAPTER 1

Past and Current Trends

The concept of occupational therapy, i.e., the use of activities in altering and/or reversing the process of mental illness, received impetus about 100 years ago during the era of moral treatment, when psychiatry had as its basic precept the inherent worth of the human being and the belief that the mentally ill were essentially normal persons who had undergone excessive social and psychologic stress.[1]

In translation of these concepts into daily living experiences for patients in mental institutions, emphasis was then placed on close and friendly association with the patient, intimate discussion of his difficulties, and the opportunity for pursuit of personally satisfying and purposeful activity. Patients were assigned to jobs in the institutions, and recreational opportunities were made increasingly available. The concept of occupational therapy began to develop rapidly. It was readily discernible that a patient's behavior changed and improved as he was able to become involved in con-

[1] Greenblatt, Milton; York, Richard H.; and Brown, Esther Lucille: *From Custodial to Therapeutic Care in Mental Hospitals.* New York: Russell Sage Foundation, 1955.

structive activity. A program of work and diversion was perceived as valuable in that it helped develop self-esteem and a sense of worthiness, diverted unacceptable behavior, and interfered with pathologic ruminations, thus changing appreciably the way in which the patient behaved.

As psychiatry began to develop as a medical science, more thought and investigation were devoted to methodologies of medical research and study in an effort to understand the causes of mental illness.[2] This, coupled with the increasing numbers of mentally ill and the complex social and cultural problems arising in a rapidly growing heterogeneous society, reflected in mental institutions, resulted in increased demands and expectations on the physician. Thus, the position of the physician-father in a closely knit, interacting, family-like setting became untenable and gave way to the role of physician-researcher-scientist, with a gradual lessening of his involvement in the daily living experiences of patients and relegation of this role to nonmedical personnel.

Changes in the structure and nature of institutions and in concepts of patient care and treatment began to impinge on the role of the occupational therapy worker. Increased pressures to meet the new expectations, as well as the diminution of close and immediate guidance of professional authority, pointed up the need for improved training and education. Emphasis began to be placed on the professionally trained worker with a good background in a growing number of eral therapeutic role to a more specific function and a refine-medical sciences, with gradual delimiting of the more gen-ment of medical and technical skills and knowledge.[3]

[2] *Action for Mental Health*, Final Report, Joint Commission of Mental Illness and Health. New York: Basic Books, Inc., 1961.

[3] Fidler, Gail S.: "The Social Field around the Hospitalized Patient." Unpublished paper.

The medical prescription became essential to allay the anxieties inherent in new responsibilities and to provide some means of guidance and direction for the developing therapist. It had added significance as a symbol of medical recognition, providing professional identification for a group striving toward professional status.[4]

Like the physician, the occupational therapist was faced with increased numbers of patients, new and increasing responsibilities in patient programming, and growing demands to increase knowledge and skill. Priorities had to be established, and the occupational therapist began to be less involved in the total daily living experience of the patient and in his role in the total institution. Along with others, the occupational therapist gradually came to consider many former responsibilities and functions as the province and concern of other staff members. In the hospital, as in industry, a division of labor became necessary, resulting in a narrowing of role and a diminution of concern for total patient-care programs.

Recreational activities and general programming with its implied diversion and play came to be less and less a concern of the occupational therapist. The occupational therapy "shop," where the constructive and therapeutic aspects of doing more specific jobs could be determined and more readily controlled and measured, became his concern.

Growing awareness of the inherent value of purposeful activity and the need to fulfill professional expectations was reflected in increasing attempts to evaluate and measure cause and effect of such programming. Gradually, in many instances, the "end product," or successful completion of a

[4] Mazer, June, and Goodrich, Wells: "Prescription—An Anachronism," *Am. J. Occupat. Therapy*, Vol. 12, No. 4, 1958.

job or project, began to be the basis for judging the mental health or recovery of the patient and, eventually, the yardstick for measuring the success and skill of the worker. Although some workers continued to feel that the inherent value of activity was in the process itself and in the "socialization" of the patient, to a disturbing extent the efficacy and success of occupational therapy itself came to be judged by others and, in some instances, even by occupational therapists on the basis of the number of patients for whom the department could provide activity and on the skill with which jobs were performed or completed.

There was increasing emphasis on proficiency in teaching a patient to become skillful in a given art or craft. This gave rise, in many instances, to specialized shops for woodworking, ceramics, printing, etc. Further impetus was provided by many Army and Veterans Administration rehabilitation programs, which emphasized the need for the patient to learn a modern, realistic, and masculine skill.

During this time psychiatrists had begun to emphasize and to be increasingly aware of the importance and significance of interpersonal relationships in contributing to emotional illness and as a means of changing pathology. Research was pointing more and more toward the significance of such relationships. Treatment techniques and procedures were being developed in the use of individual and group relationships, and these were beginning to be considered the most significant factor in the treatment of the mentally ill.

To those persons and professional groups who had become increasingly removed from patients in the process of developing their professional role and/or those who had been placing significance and value on the completed job or project, this new orientation was strange and its implications, fright-

ening. To the occupational therapist it meant a reassessment and re-evaluation not only of concepts of patient treatment, but subsequently of methodologies.[5]

Theories of interpersonal relationships had an impact on the practice of psychiatry and considerably influenced the concept of the role of the occupational therapist in the treatment of psychiatric patients. The pendulum began to swing in the other direction, and many therapists perceived the relationship between the patient and the occupational therapist as considerably more important than the activity, to the extent that the job or the activity began to receive less and less attention in favor of the development of a meaningful relationship with the patient. In some instances, this has developed to such an extreme that the selection of an activity is left entirely to the whim of the patient, or it is perceived that the activity or the process of doing is incidental to occupational therapy, and the relationship between the patient and the occupational therapist is considered to be of greater significance than any other factor.

Increased investigation in the area of interpersonal relationships inevitably has begun to create an interest not only in the interaction of human beings, but also in the milieu or social-cultural community in which one lives and is influenced. The increased interest of the social scientist and anthropologist in the social systems and cultures of psychiatric hospitals has brought about changes that explicitly and implicitly influence the role and function of all persons involved with patient care and treatment. In addition, the use of drugs has altered the nature and structure of mental hospitals.

[5] West, Wilma (ed.): *Changing Concepts and Practices in Psychiatric Occupational Therapy*. Am. Occupational Therapy Association, 1959.

As roles and concepts are reassessed and refined, the occupational therapist, as well as many other professional persons, has encountered many difficulties and will continue to do so. There are many varieties of patient-treatment programs, with as many variations in emphasis and basic orientation as there seem to be people involved in programming. These are the growing pains of a young profession allied with a rapidly growing and changing medical science.

Understanding the history of a profession is only part of what is needed to gain perspective on the field. Somewhat more difficult is understanding current trends and the divergence of explorations. In this chapter we will summarize some of the subjects that have been brought into focus by articles published in this field. No attempt has been made to cover every publication or to cover every aspect that has been discussed in print, but rather our aim is to highlight some of the major areas.

A dozen or more articles have recently been concerned with the problems of education, preparation, and licensure. As might be expected, the occupational therapist is showing a concern for professional qualification, and in the attempt to achieve a more adequate educational program, it is of course necessary to achieve a better definition of the task performed. Both features have been discussed and related to the subject of licensure. Each of these problems is basically the same as those faced by other professions. In the search for self-improvement, it is always necessary to define more clearly the area of competence and to train more specifically for it. Premature licensure can restrict development, whereas a delay can allow unnecessary chaos to develop.

Some of the writings have helped to focus on the evolu-

tion of the profession. For instance, one of the major studies undertaken by the American Occupational Therapy Association recently has been a review of the changing concepts and practices in psychiatric occupational therapy.[6] Also, in the several publications aimed at revision of curriculum, much attention necessarily has been given to the current direction of changes in the field. These changes have been reviewed in the light of the general professional evolution of any special group but also in the light of special conditions that pertain to occupational therapy alone. In various ways, the writings have noted a most important shift away from a humanitarian but completely adjunctive function in respect to patient treatment to a more adequate professional role in treatment planning. At the same time, a somewhat separate role has been found in the rehabilitation of patients who have undergone more definitive psychiatric treatment. With these patients, greater responsibility and attention are directed to social problems, with psychopathologic problems taking a secondary role. These differences emphasize the need to define a professional role and function to be sure that the different types of activity are, in fact, part of the same profession.

There are also other developments parallel to those in other professional groups. For instance, a tendency has developed away from actual contact with the patient. With greater knowledge, competence, and status, it is deemed fitting to assume more of the functions of planning and to have other persons, such as occupational therapy aides, carry out the plans and make the actual contact with the patient. Several papers have commented on the use of aides and the

[6] *Ibid.*

problems of training them. Whether this procedure changes the character of what constitutes a professional occupational therapist is still a point to be investigated.

Administrative problems are, of course, a practical concern everywhere and deserve a fair share of attention. These problems might be considered as falling into two categories: first, the administrative relationship between occupational therapists and the rest of the hospital staff and, second, the departmental organization and the relationships of occupational therapists to each other. It is our impression that more attention could be given to both these areas with great benefit to the profession, since it has been repeatedly demonstrated that some administrative organizations are much more effective in helping with psychiatric problems than others. The appearance of the therapeutic community and the stress on milieu therapy, as well as the increasing number of sociologic studies of hospitals—all underscore the importance of this aspect of the effectiveness of occupational therapy. Several persons have described the problems of establishing new occupational therapy departments and have included their observations about the importance of good staff relationships. One of the most notable of these was the description of the organization of occupational therapy at the Illinois State Psychiatric Institute.[7]

The relationship between occupational therapy and rehabilitation and socialization has always been very close and has at times led to confusion in mistaking one for the other. Of the recent publications we have reviewed, approximately 20 per cent are addressed specifically to the application of occupational therapy techniques to rehabilitation and social-

[7] Owen, Carolyn: "An Activities Group Charts Its Own Course," *Mental Hospital,* Vol. 11, No. 10, 1960.

ization. Many of these are aimed specifically at the chronic schizophrenic patient, but much emphasis has also been placed on geriatric problems. It is worth noting that this literature mentions activities devised for the group and describes programs considered adequate for any patient who happens to be chronic schizophrenic or senile. This is in contrast to programs in acute psychiatric services, where activities are generally structured around the unique pathology of the individual.

We still find studies concerned with comparing one group of patients having occupational therapy with another group without occupational therapy. By now many studies have proved that involving patients in activities is better than not involving them. However, several studies have been aimed at specifying the type of involvement. For instance, a report entitled "Group Centered and Individual Centered Activity Programs" [8] attempts to evaluate two possible methods of approaching patient activity. In this study one group of patients was given a definite assignment of lawn mowing and another group was taken into an occupational therapy shop and urged to make their own decisions in the customary manner. With the same therapist in charge of each group, the lawn-mowing group showed the greatest improvement. Studies such as this can help define the significant aspects of the patient's contact with occupational therapy and avoid the easy temptation of applying any kind of "busy work."

By starting from a different hypothesis, a number of studies have stressed the significance of using activities that relate to the premorbid experiences of patients. In one study, typing was used with patients who had been employed as

[8] Efron, Marks H., and Hall, R.: "Group Centered and Individual Centered Activity Programs," *Arch. Gen. Psychiat.*, Vol. 1, No. 5, 1959.

clerks and typists prior to their illness. In another study, educational techniques such as would be comparable to the public school experience were employed. A third group reported that routine testing of vocational background was employed in planning assignments of activities within the hospital. These efforts have had a twofold effect of making the activity more comprehensible to the patient and, therefore, more likely to be of therapeutic benefit. At the same time, the activities are related to rehabilitation and future usefulness. Studies of this type emphasize the relationship between the activity and the individual patient rather than defining types of activities that are therapeutic for just about any patient.

Several reports reveal the use of occupational therapists in dealing with discharged patients and their community relationships. These efforts are specifically rehabilitative, but they obviously show that the occupational therapist is considered to have useful techniques for this very important effort. Directed to the problem of preparing for the future, these efforts are more oriented to vocation and less to past experience or current pathology.

A specific study, called the "Minnesota Follow-up Study," [9] is concerned with research into the relationship between hospital activity and subsequent community activity. This effort will, hopefully, define somewhat better the "practical values" in occupational therapy. Whether this feature of occupational therapy can be useful in changing patient pathology is still difficult to demonstrate.

In addition to the general problem of understanding the function of activity programs for patients in general, an in-

[9] Fry, Violet B.: "The Minnesota Follow-up Study," *Am. J. Occupat. Therapy*, Vol. 14, No. 4, 1960.

creasing number of program descriptions have been aimed at specific categories of patients. For instance, one paper describes activity programming for the aggressive child. This approach is again attentive to the individual patient but emphasizes the type of pathology rather than his past experience. Another study evaluates a planned program for the hostile child, and a third describes programming for schizophrenic children. Other papers with a similar objective deal with problems raised by alcoholics and schizophrenics and so forth. In studies such as this it must be assumed that patients manifesting the same behavior or having the same diagnosis can benefit from similar or identical treatment. On the basis of this hypothesis, it is possible to plan some more or less standardized occupational therapy procedures. How much the past experience of the individual or his other unique characteristics must be acknowledged is yet to be studied.

One paper describes a total program making full use of this information. It is entitled "Psychological Tests in Planning Therapy Goals." [10] This, of course, deals with the process of sorting patients into various categories for which presumably differing occupational therapy programs will be planned. Specifically, they dealt with children and, on the basis of testing, distributed the children into four different categories. Case examples of these various diagnostic groups help to clarify the thinking process involving their definitive therapy. Such programs dedicated to a specific thesis will give the most effective test of the value of a given approach.

These observations about special problems constitute one method of trying to understand the essential elements in oc-

[10] Llorens, L.: "Psychological Tests in Planning Therapy Goals," *Am. J. Occupat. Therapy*, Vol. 14, No. 5, 1960.

cupational therapy and how they work. Other efforts have been made by trying to relate the various factors involved in occupational therapy to the same factors in the therapeutic processes of other professions. For instance, several articles have paid attention to the specific relationship between the patient and the therapist insofar as this is comparable to any psychotherapeutic dyad. This aspect is most thoroughly discussed in an article called "The Therapeutic Use of Self" by Jerome D. Frank.[11] The same issue is also thoroughly covered in "Changing Concepts and Practices in Psychiatric Occupational Therapy." [12]

In practically all settings, occupational therapy is carried out with groups of patients, and certainly group dynamics are a factor in the treatment impact. Very little attention has been paid to this subject, however, and only one article is devoted specifically to group factors. This is "The Occupational Therapist Works with Groups" [13] by Jack R. Gibbs, Ph.D. It is in general an orientation to group dynamics rather than a description of any specific occupational therapy studies.

Two individual papers stand alone in describing the evolution of the therapeutic relationship in some detail. The first of these is "A Dynamic Therapy for Schizophrenia," [14] in which a specific attempt is made to have the patient live through a re-enactment of a significant emotional issue. This is a specific attempt to apply a theory that originated else-

[11] Frank, Jerome D.: "The Therapeutic Use of Self," *Am. J. Occupat. Therapy*, Vol. 12, No. 4, 1958.

[12] West, *op. cit.*

[13] Gibbs, Jack R.: "The Occupational Therapist Works with Groups," *Am. J. Occupat. Therapy*, Vol. 11, No. 4, 1958.

[14] Schaefer, D., and Smith, J.: "A Dynamic Therapy for Schizophrenia," *Am. J. Occupat. Therapy*, Vol. 12, No. 5, 1958.

where rather than to evolve a theory derived directly from observation of standard occupational therapy. On the other hand, a paper called "Occupational Therapy Student Research Project" [15] does describe specific phases in which patients choose activities according to different patterns. The author defines a first period when patients have a free choice of activities, which are then observed and evaluated for diagnosis on the hypothesis that activities selected by emotionally ill patients are influenced to a greater extent by psychopathology than by premorbid interests or skills. This phase is followed by a period when the activities are planned by the therapist to effect the treatment according to the therapist's understanding of patient need. A final stage occurs as the patient improves and is allowed to make a free choice of activities because he is now sufficiently integrated to choose things for future usefulness or present satisfactions.

One more area that must be understood in order to appreciate fully how occupational therapy works is the aspect of object relationships. The only serious efforts to approach this feature from a dynamic viewpoint have been made by Dr. Wittkower and Dr. and Mrs. Azima. They speak of the use of objects to foster regression as well as to give gratification to originally frustrated needs. Principally, in two articles entitled "Dynamic Aspects of Occupational Therapy" [16] and "Outline of a Dynamic Theory of Occupational Therapy," [17] they have made a most serious attempt to apply concepts of psychopathology and psychotherapy to the occupational

[15] Huntting, Inez: "Occupational Therapy Student Research Project," *Am. J. Occupat. Therapy*, Vol. 14, No. 4, 1960.

[16] Wittkower, E., and Azima, H.: "Dynamic Aspects of Occupational Therapy," *Arch. Neurol. & Psychiat.*, Vol. 79, No. 6, 1958.

[17] Azima, H., and Azima, F.: "Outline of a Dynamic Theory of Occupational Therapy," *Am. J. Occupat. Therapy*, Vol. 13, No. 5, 1959.

therapy situation, especially on the basis of object relations, which is after all the traditional hallmark of occupational therapy.

A completely different approach to the problem of understanding occupational therapy is the use of field surveys to study various attitudes of psychiatrists, occupational therapists, and patients. These are certainly helpful in understanding the current uses and failures in the practice of the profession. One such study was reported as "A Partial Field Survey of Psychiatric Occupational Therapy." [18] Another such study is still being conducted with the cooperation of the American Psychiatric Association. Such studies are helpful in pointing out the inconsistencies and inadequacies in both theory and practice. These studies do indicate that the psychiatrist and the occupational therapist who are in a position to deal with each other do not in fact sufficiently understand each other. This issue is discussed quite significantly in an article entitled "Prescription—An Anachronism." [19] The authors point out that, in general, the psychiatrist does not understand occupational therapy sufficiently to prescribe with any specificity what an occupational therapist should do. They point out that prescription should really be an ongoing communication between psychiatrist and occupational therapist. This improves both communication and understanding.

As stated earlier, this review is simply a brief survey of current efforts to study the field of psychiatric occupational therapy. It is not exhaustive but is a selection of some of

[18] Azima, H., and Wittkower, E. D.: "A Partial Field Survey of Psychiatric Occupational Therapy," *Am. J. Occupat. Therapy*, Vol. 11, No. 1, 1957.

[19] Mazer and Goodrich, *op. cit.*

the major themes that are of present concern to the practitioners who are working at this profession.

ADDITIONAL REFERENCES

DEANE, W., and DODD, M.: "Educational Techniques for the Rehabilitation of Chronic Schizophrenic Patients," *Am. J. Occupat. Therapy,* Vol. 14, No. 6, 1960.

ELLIS, M., and BACHRACH, A.: "Psychiatric Occupational Therapy: Some Aspects of Roles and Functions," *Am. J. Psychiat.,* Vol. 115, No. 4, 1958.

KRYGAR, C.: "Clerical Work in Psychiatric Occupational Therapy," *Am. J. Occupat. Therapy,* Vol. 14, No. 6, 1960.

LLORENS, L., and YOUNG, G. S.: "Finger Painting for the Hostile Child," *Am. J. Occupat. Therapy,* Vol. 14, No. 6, 1960.

MAEDA, EDITH: "Activity Programming for the Aggressive Child," *Am. J. Occupat. Therapy,* Vol. 14, No. 4, 1960.

ROUSOS, I.: "Planning Occupational Therapy for Schizophrenic Children," *Am. J. Occupat. Therapy,* Vol. 14, No. 6, 1960.

SOMMER, ROBERT: "Professionalization and Occupational Therapy," *Am. J. Occupat. Therapy,* Vol. 14, No. 6, 1960.

———: "Occupational Therapists as Specialists in Mental Hospitals," *Am. J. Occupat. Therapy,* Vol. 12, No. 5, 1958.

WADE, BEATRICE D.: "From the Study of State Licensure," *Am. J. Occupat. Therapy,* Vol. 14, No. 2, 1960.

WEGG, L.: "The Essentials of Work Evaluation," *Am. J. Occupat. Therapy,* Vol. 14, No. 6, 1960.

CHAPTER 2

Orientation to this Approach

There exist many theories concerning the treatment of the psychiatric patient and multiple differences in points of emphasis within any given one of these theories. It is essential, therefore, to clarify that orientation and those concepts inherent in our thinking concerning the meaning and use of activities in the treatment of psychiatric patients.

It is our belief that all treatment programs for psychiatric patients should occur in a setting that is oriented to therapy in all aspects and that all persons involved in such programs should be perceived as active participants in the therapeutic process. The nature and extent of involvement for any staff member will depend on his skill, the particular orientation in which therapeutic planning occurs, and the nature of the corrective emotional experiences deemed essential for any given patient or group of patients.

At the risk of oversimplification, we would describe a therapeutic program as one that offers the patient experiences that foster collaborative relationships wherein he may explore concepts about himself and others, re-evaluate these

assumptions, gratify some of his frustrated basic needs and drives to the extent that he may develop a more solidly integrated self-identity and a more realistic concept of others, and consolidate these growths through continued experimentation and exploration. It is implicit that such corrective emotional experiences can occur only to the extent that the culture or milieu of the institution supports and provides such experiences by the nature of its organization.

Treatment programming is then directed toward the pursuit of these goals, and the role of the professional worker in treatment is to apply his particular skills, knowledge, and techniques so as to sustain such orientation and move toward realization of such goals. In addition, such a definition implies active interaction and collaboration of all personnel, not only in planning and implementing treatment, but in developing and sustaining a culture or milieu in which pursuit of these goals is possible.

It soon becomes evident that such an orientation to total treatment creates some problems in role definition. While the physician carries over-all medical responsibility for patients, each worker must be expected to discharge his professional responsibility for both creative leadership and creative interaction. It is also evident that, professional or not, each person who comes in contact with the patient impinges on the patient and is necessarily involved with him. In addition, all persons share the same goals for patients, with differences sometimes evident only in the techniques used to achieve these goals, whereas at other times little if any difference exists even in techniques.[1] Thus, it becomes increasingly difficult for the occupational therapist or others

[1] Fidler, Gail S.: "Role of Occupational Therapy in Multi-discipline Approach to Psychiatric Illness," *Am. J. Occupat. Therapy,* Vol. 11, No. 1, 1957.

to define specific goals and objectives that are unique and particular to each discipline. Difficulty in circumscribing a specifically unique role may constitute a threat to one's professional identity and may understandably provoke anxiety. Such anxiety makes it difficult to recognize the necessity for common goals in patient treatment and the value such sharing has in increasing communication, interaction, and concerted effort on behalf of the patient and in forming a basis from which differences may be defined.

We feel that occupational therapy in psychiatry is basically and primarily a communication process and can be effectively used and understood as an integral part of the therapeutic program only to the extent that one is able to perceive it as such. As a communication process, occupational therapy is concerned with action, the meaning of action, its use in communicating feelings and thoughts, and the use of such nonverbal communication for the benefit of the patient.

We used action to express and communicate feelings and needs long before we developed the capacity to use the more sophisticated process of verbal communication. During infancy and early childhood the human being relies heavily on action as a means of communicating and relating to others. Skills in verbal communication develop later, as one matures, and man never completely loses his reliance on action as a means of communication. Comprehension of the unconscious and conscious mechanisms of action or behavior is essential to the understanding of the human being.

We use action to communicate feelings and attitudes in everyday experiences. We talk about persons "behaving in a friendly manner," "acting hostile," "acting dependent," or "frightened," etc., and seldom do we need verbal confirma-

tion for the message to get across to us. We use action to deny feelings to ourselves and to others. In the process of learning to relate to others, we fairly readily perceive that certain feelings we have are unacceptable to others. Such awareness then generates feelings of anxiety, and we devise means to deal with or deny such feelings. There are those who, when frightened, behave in an aggressive manner; the insecure may behave in an omnipotent manner; and those with dependent needs may act with independence and be contemptuous of those who are dependent. We use action directly to gratify our needs or to sublimate those needs that cannot be directly gratified. Our need to be loved or infantilized may be gratified by oral action, such as eating, smoking, singing, and speaking, or by more subtle sublimation, such as taking care of others, giving to others, or entering helping professions.

Psychiatry, and all sciences involved in attempts to understand the human being better, continue to explore the complex nature of communication as a key to comprehending behavior and thus to increase man's capacity to function. A review of the literature in the area of communication is overwhelming, but much of this material has direct implications for occupational therapy. Jurgen Ruesch [2] and others explore the difficulties in bringing together in a meaningful way thought, action, and language and emphasize the vital significance of nonverbal communication in the process of relating and interacting with others. One remarkably succinct paper that may be directly meaningful to the occupational therapist was written by Maria Lorenz.[3] In this paper

[2] Ruesch, Jurgen: *Disturbed Communication.* New York: W. W. Norton & Co., Inc., 1956. ———: *Therapeutic Communication.* New York: W. W. Norton & Co., Inc., 1961.

[3] Lorenz, Maria: "Problems Posed by Schizophrenic Language," *Arch. Gen. Psychiat.*, Vol. 4, No. 6, 1961.

Dr. Lorenz presents the hypothesis that communication is essentially "the process of transforming inner private subjective experiences and thoughts into external public form, accessible to recognition by people at large, where it can then acquire validity in the shared 'real world.'" This may also be used as a definition of the inherent concept in occupational therapy.

Interpersonal difficulties in communication may stem from problems in becoming aware of the intrapsychic thinking, in organizing and translating this thinking into "a thought," or in selecting common, recognizable symbols to express the thought in such a way that it is understood by others. Viewing this aspect of communication, then, one can better comprehend why the creative art of many patients is difficult to understand and why such understanding can occur only in collaboration with the patient. Also, creative expression may be threatening because of the expectation that one become aware of and communicate intrapsychic feeling and thinking. Likewise, the value of structured activities for persons who have difficulty in selecting appropriate, recognizable symbols may be better appreciated.

Such a frame of reference about occupational therapy brings into focus several aspects of immediate significance. These may be specified as

1. The action itself.
2. Those objects that are used in the action process, as well as those that result from the action.
3. Those interpersonal relationships that influence the action and are in turn influenced by it.

These three areas, then, may be perceived as constituting the occupational therapy experience. In essence, the action

or activity and the objects used in the action process function as catalytic agents or stimuli eliciting intrapsychic and interpersonal responses or reactions, which, in turn, are used in whatever way is appropriate to patient needs and treatment orientation. It is obvious that understanding the psychodynamics of action and the meaning of objects will determine the therapist's capacity to understand a response, as well as to predict and therefore structure a given response. Likewise, knowledge and training in dealing with intrapsychic processes and interpersonal responses make it possible to use and structure these to the benefit of the patient.

Thus, the education and training of the occupational therapist must be directed toward knowledge and skill in

1. The psychodynamics of action or behavior to the extent that one is able to be knowledgeable about the patient's communication and to use this in a more or less measurable and predictable way to his benefit.
2. The real and symbolic meaning of the objects used in the course of action to the extent that one may use these appropriately to elicit desired action and response and to understand response.
3. The psychodynamics of interpersonal relationships to the extent that a collaborative relationship may be developed, understood within the gestalt of the occupational therapy experience, and used knowingly.

Implicit in all of these are an awareness and appreciation for the phenomenon of the unconscious. Without a sound understanding of the unconscious, the concept of occupational therapy can be neither realized nor understood.

Within this frame of reference then, we may begin to

visualize the potential of occupational therapy in several areas. These may be categorized as evaluation and diagnosis, treatment, mental health processes, and rehabilitation.

Within the hierarchy of medicine and consequently within medical institutions, the privilege of "treating" commands a high status and indicates that those given this "right" have received the benefit of extensive formal education and training and possess a relatively high degree of skill and knowledge. Thus, persons who are designated to treat patients have a higher status and greater prestige than those who are involved in other roles and functions within the hospital. On this basis it is not difficult to understand some of the reasons for almost everyone's need to be associated with treatment and for the need to explain much of what goes on within a hospital as treatment.

An example of this may be seen in the increasing numbers and varieties of "therapies" in hospitals and the struggle of each of these to obtain recognition and status as treatment. The impact of the prestige associated with "treating patients" may also be perceived in the attempts to explain both rehabilitation and sociologic concepts or milieu as treatment procedures, and the almost exclusive commitment of occupational therapy to treatment may be seen as a reflection of this concern. Expansion of the field of psychiatry into areas of the social sciences with the consequent development of therapeutic communities, patient government, patient-initiated activity groups, etc., has increased the confusion about what is and what is not treatment, and resolution of the issues inherent in such a dilemma becomes increasingly necessary.[4]

[4] Fidler, Jay W.: "Hygiene versus Therapy in Psychiatric Practice," *Psychiatry*, Vol. 25, No. 4, 1962.

Such broadly generalized concepts concerning treatment have made it extremely difficult to look objectively at patient needs, at what one is doing as well as what one should be doing. For clarity of thinking, for research and investigation, and for the ultimate good of the patient, we need to define more clearly and objectively what we are doing and its rationale. One step in this direction is to make some differentiation of treatment, mental health processes, and rehabilitation—not only to understand better what we are doing but, hopefully, to develop a finer appreciation of the value and significance of each of these. Thus, our approach attempts to differentiate treatment, mental health processes, and rehabilitation.

Treatment may be defined as that process that consciously applies a given body of knowledge and skill in an effort to change or correct pathology. Treatment then is directed toward the elimination of pathology and as such is concerned with the illness of the patient.

There are varying schools of thought embracing a variety of concepts with regard to the dynamics of etiology and treatment. For our purpose these may be perceived as falling into three general orientations.

1. The psychoanalytic approach places primary emphasis on the unconscious, exploring the unconscious needs, drives, and conflicts of the patient and resolving these by means of awareness and understanding within the therapeutic relationship.

For example, Betty, in individual sessions with the occupational therapist, used action with clay to explore the meaning of her autistic withdrawal, her severe stomach cramps, and her suicidal attempts and, through the action and rela-

tionship, was gradually able to become aware of her anger, to explore and begin to understand the nature and reasons for her rage.

2. The supportive approach recognizes the significance of the unconscious phenomenon and helps the patient to gratify his needs by sublimation. It deals with conflicts by establishing constructive defenses rather than by exploring and uncovering.

For example, John's feeling of insecurity, his lack of masculine identity, and fear of his hostile impulses created a need to feel that he was always in control, to always test people in situations, and to prove his masculinity. His secondary needs to control, to be suspicious, to investigate, to prove he was "a man" were gratified by his involvement as editor in the hospital newspaper group. The group's obvious respect for his abilities provided acceptance and security and was additional support to him in developing a more realistic self-concept and identity.

3. The directive or repressive approach utilizes the patient's existing ego integration to repress unacceptable feelings and behavior. It is expected that the patient can and will suppress unacceptable behavior if he is helped to do so through structure and a relationship which is supportive and which requires appropriate behavior. This approach relies heavily on secondary gains from appropriate behavior.

For example, Cynthia, an angry, acting-out adolescent whose behavior had made it impossible for her to remain outside a hospital, was placed in an adolescent group where limits were very clearly defined and where she was expected to behave appropriately. Good behavior was rewarded, and deviant behavior resulted in denial of privileges and freedom. Approbation and approval were the rewards she experienced.

Mental health processes may be defined as those methodologies that are directed toward developing and sustaining an environment and culture based on the inherent worth and integrity of the human being. Such concepts recognize man's need for love, acceptance, and a sense of belonging and his need to share with others and to perceive himself as a productive, contributing member of his society. Organizational and administrative procedures, patient government, patient-initiated activity groups and recreation, work, and opportunities to experience and discharge a sense of responsibility, to make decisions, and to accept responsibilities for such decisions are only a few examples of such processes.

Since there is a recognizable correlation between the effectiveness of treatment procedures and the nature of the culture or milieu in which they occur, a major professional responsibility of the occupational therapist is the use of his skills and knowledge of the psychodynamics of activities and the symbolic significance of objects toward enhancing the milieu or social structure in which treatment occurs.

Those activities and objects that an occupational therapist uses within this frame of reference must be broad enough in scope to fulfill the desired functions. It is unfortunate that a delimiting of scope has occurred to the extent that occupational therapists generally feel comfortable only in the area of arts and crafts and are, thereby, seriously limited in the extent to which they may become involved in treatment and patient-care programs. A therapeutic milieu and the skills and techniques of implementation are essential, and the real potential of therapeutic endeavor within an institution will not be realized until more growth in this aspect of patient care is achieved. Likewise, occupational therapy will not fully mature as a profession until it recog-

nizes and accepts the essential values of the total concept of patient care and assumes its appropriate responsibility in this area.

Rehabilitation may be defined as those efforts and procedures that are directed toward helping the patient learn to use more effectively his existing integrative capacities and his assets and abilities toward developing and refining skills that will enable him to assume appropriate economic and social responsibilities outside the hospital. Prevocational exploration, on-the-job training or exploration, reintegration into the community, and discussion groups and learning experiences in how to apply for a job, how to budget, and many other of the realistic aspects of living outside an institution are the concerns in this area.

The process of differentiating treatment, mental health procedures, and rehabilitation does not assign a set of values to these. Certainly the extent to which rehabilitation as we have defined it can occur or be successful is dependent on the existence of sound treatment and mental health procedures. Likewise, the extent to which treatment may be successful is determined to a considerable degree by the milieu or culture in which it is practiced. It is not uncommon to observe patients experiencing a diminution of anxiety and pathologic symptomatology when they enter an institution that employs good mental health procedures. It is also evident that if the patient does not receive sufficient help and guidance in resuming life in the community outside the hospital, he may well return to the more protective environment of the hospital. The proportionate value of each of these factors must be determined by the multiple needs within a given situation at a given time for a given patient.

Finally, the use of the medical prescription certainly needs

to be explored since many of our inherent concepts concerning occupational therapy in psychiatry impinge upon this. It is our belief that the use of a written prescription in many instances inhibits more effective communication and exchange of ideas. The structure of many institutions, as well as the reluctance of the occupational therapist to communicate verbally, tends to support the written prescription as an avoidance of face-to-face contact and interaction.

In addition, one of the basic responsibilities inherent in professional identity is the capacity to make decisions concerning one's area of patient treatment. In many instances, the occupational therapist's reliance on a prescription implies a need for or an expectation of rather explicit directions about how to program for or treat a patient. It would seem to imply further that the physician should assume much of the responsibility for making decisions and for direction in occupational therapy. It has been our experience that most psychiatrists would prefer that the occupational therapist assume appropriate professional responsibility and work in a collaborative relationship with them. It is the responsibility of the occupational therapist to know which patients are most likely to gain from which occupational therapy experiences and which of the patient's needs and conflicts can be dealt with in occupational therapy. We feel that basically "permission" to treat or work with a patient is implicit in the hiring of the therapist, and the questions concerning individual patient problems can only be effectively worked out collaboratively.

The occupational therapist's tenacious hold on the medical prescription or "activities medically prescribed" may also be perceived as a means of identification with treatment or medicine. It is hoped that one's professional identity may

ultimately stem from basic knowledge and skill and the capacity to discharge the responsibilities inherent in a profession.

This, then, outlines our basic frame of reference concerning patient care and treatment. Such an orientation has multiple implications for the occupational therapist. Basic to functioning as a therapist is the attainment of a body of knowledge that enables one to develop and refine essential therapeutic skills. The occupational therapist's successful functioning is dependent on the interpersonal relationship and has as its distinguishing mark the use of activities and objects based on a body of knowledge concerning the psychodynamics of relationships and action, the symbolism of objects, and the processes of response to these. Such knowledge and its artful use constitute the core of psychiatric occupational therapy.

ADDITIONAL REFERENCES

DEVEREUX, GEORGE: "The Social Structure of the Hospital as a Factor in Total Therapy," *Am. J. Orthopsychiat.*, Vol. 19, No. 3, 1949.

FRANK, JEROME D.: *Persuasion and Healing.* New York: Robert Brunner & Co., 1962.

FRENCH, THOMAS M.: *The Integration of Behavior.* Chicago: University of Chicago Press, 1957, Vol. 1.

KING, H. E.: *Psychomotor Aspects of Mental Disease.* Cambridge, Mass.: Harvard University Press, 1954.

RUESCH, JURGEN, and BATESON, GREGORY: *Communication: The Social Matrix of Psychiatry.* New York: W. W. Norton & Co., Inc., 1951.

SULLIVAN, HARRY STACK: *Conceptions of Modern Psychiatry.* New York: W. W. Norton & Co., Inc., 1953.

CHAPTER 3

Theory of Object Relationships

Probably the thorniest problem in psychiatric occupational therapy is handling the concepts that are necessary to understand the psychodynamic significance of specific activities. The psychodynamic significance must be comprehended in order to understand the psychotherapeutic impact or the psychologic diagnostic value of what occurs in the occupational therapy relationship. This is a field that has not been extensively explored. The psychiatrists and psychoanalysts, on the whole, have not been especially interested, and the occupational therapists seem unprepared to theorize extensively about this. Some of the difficulty in this area, but certainly not all of it, is caused by the ambiguity of the term "object relations" as it is used in psychiatric literature. Because patients in occupational therapy do become involved with objects, it is tempting to feel that this involvement, therefore, is related to the psychoanalytic concept of object relations. Unfortunately, the applicability is only partial.

The most common use of the term "object" in psychiatric literature is in reference to persons rather than things, al-

though there are times when it is used also to refer to man-made objects. It seems clear that the importance of "things" lies largely in their representation of human activity. Hence, the interpersonal aspect of object relations cannot be ignored. This category of objects as separate from persons is also acknowledged in the scoring of the Rorschach test, where they are designated with a separate symbol. To qualify as an object for purposes of our discussion here, a thing must be identified as that with which an instinctual impulse is gratified. It is this feature of instinctual gratification that gives it importance as a diagnostic or therapeutic tool. On the other hand, we are not concerned in this discussion with persons directly as objects.

To help understand the emotional significance of objects, we will briefly review some of the relevant theory about the development of object relationships. This has been largely expressed in interpersonal terms, but it is basic to our thinking. On the basis of this theory, we can then attempt to relate the activities used in occupational therapy to these developmental concepts. Very little attention has been given to this aspect of psychiatric occupational therapy in the literature. The few references coming from the work in Montreal have been mentioned in our review of current trends.

It is assumed in our understanding of how object relations develop that when a child is born, he has no ability to differentiate between those sensations produced outside his body and those produced within it. There is psychologically then no possibility of an object relationship, i.e., a perceived relationship between self and other. The first perception of emotional and instinctual significance is an ability to distinguish the mother or the person who produces the

gratifying behavior for the infant from the many stimuli received. At the point when the child recognizes the mother's face and smiles in response to it, he is finding that this "object" is related to the gratification of his hunger. He then develops an anaclitic love-object relationship characterized by complete dependence on the mother for gratification of all needs and a seeming unawareness of self in contrast to the comparatively sharp awareness of mother. Such a relationship also characterizes some adult psychotic personalities.

Once an object other than self has been identified, an awareness of the infant's own body image and a perception of that which belongs to itself very rapidly develop. These perceptions lead to the possibility of awareness of an instinctual gratification derived from his own body. This awareness is identified as a narcissistic object relationship, which is found normally just before the development of speech and later is reactivated in puberty by having attention drawn to the bodily changes occurring at that time.

Finally, with the development of speech and the ability to form abstract concepts, the individual learns to search with increasing effectiveness for objects to gratify instinctual needs and to reduce tension. In the process, more mature object relationships are formed and a more mature body image and self-identity develop concomitantly. Personal relations are more mature when the individual sees the identity between himself and other selves. It is at this point that other people can evoke sharing and cooperating responses. People are no longer simply "used" for immediate gratification. In relation to things, maturity is reflected by better discrimination among objects and greater ability to use things to improve human relationships. Things will no longer be in themselves the basis for security or ultimate gratification.

Mature object relationships then depend on an ability to distinguish the object in question from other objects and on a well-organized personality having a good self-concept as well as object concept. This certainly implies that those patients who are more severely disorganized are more likely to have narcissistic or anaclitic object relationships and that their perception of the materials employed in occupational therapy will be different from that of the occupational therapist, who has more mature object relationships.

In dealing with pathologic personalities, three concepts will prove useful in understanding the uses of occupational therapy. The first is that object relationships develop where there is instinctual gratification related to the object. This gratification may not be achieved directly from the object but simply may be associated with a prior gratification, just as music is so commonly reminiscent of special situations or interpersonal incidents that were occurring when the music was heard. This gratification or, at times, painful experience will focus attention on the object and increase chances for identifying it among all other comparable objects. If no emotional involvement has occurred, the object will have no "meaning" and, therefore, no object relation.

The second important concept is that object loss produces a more or less standard reaction, although the severity of the reaction varies considerably, depending on the significance of the person or thing lost. The usual results of object loss are dejection, loss of interest, loss of capacity to love, inhibition of activity, self-reproach, and expectation of punishment. All these reactions are likely to be more severe if the relationship to the object was of a narcissistic character. They do occur in mature object relations, but the versatility of the mature person finds sufficient gratification in many different

objects so that any one represents a lesser part of the total emotional economy. At the opposite extreme, in the setting of an anaclitic object relationship the loss will be a totally devastating experience.

The third major consideration is in respect to schizophrenic reactions. In schizophrenia it has often been found that object relationships are of a most primitive kind, and identification is made rather crudely, so that one object is rather readily exchanged for another. Emotional reactions will occur unpredictably over things having very little apparent basis for the significance implied by these reactions. On the other hand, object loss may produce much less evidence of a grief reaction than one is led to expect.

What benefits can be derived from a given activity for the production of a given object are not entirely the result of the stage of the patient's emotional development. There are some characteristics of the material used or the action required that strongly predispose to one type of effect in contrast to others. For instance, many different people working independently have developed similar treatment techniques in which they give patients those objects believed to gratify oral needs. Food, bottle, pillows to be stroked or sucked, and candy seemed consistently to elicit interest from severely regressed (i.e., oral) patients. In other instances, patients have been given material such as clay or finger paints, which presumably elicit anal gratifications.

When we turn to more highly structured materials, the instinctual significance is often more ambiguous, and the patient will experience it in terms of his own current emotional needs and his past experience with similar materials. On this basis, the type of interest and the emotional support given vary from patient to patient and may vary from time

to time in the same patient. To date, there has been very little effort to study activities with a standardizing process to list the most common types of response. It is possible to give people a variety of activities and have them express their subjective experience while they are involved in the activity. If this were done on a sufficiently wide basis in some very rough approximation to the way in which Rorschach responses have been standardized, it would put us on more certain ground in understanding the impact of each activity. We would then be more sure of ourselves when interpreting the reaction of a patient whose response is not characteristic for the given activity.

Among the features of an activity that will ultimately determine what it can possibly do for the patient is the amount of physical motion involved. This is related in some instances to the amount of gratification achieved. If the motion required is large and vigorous, the associated emotions are more likely to be aggressive or hostile than if motions are small and finely controlled. Another feature is the resilience, rigidity, or fragility of the material employed. For instance, if the patient has a strong need to control his environment, he will feel comfortable with more pliable materials. The patient who fears his own destructive impulses may be panicked by easily breakable materials. Of similar importance is the individuality of the product being made. Some things can be made in a very stereotyped and patterned manner with no individual identity. Other objects with more artistic potential are almost necessarily so individual that they can immediately be distinguished from all others, as is the case with painting or sculpture.

The foregoing observations will help in determining the significance of an activity to the patient. These are only part

of what is required, however, and the difficulty that confronts the occupational therapist confronts everyone who works with psychiatric patients. It is the need to know the subjective experience of the patient when the patient does not and cannot communicate it directly to the therapist.

The variety of subjective experience may be sampled by looking at the possibilities related to the making of a pottery vase. For the therapist, this may be accepted "objectively" as a more or less beautiful, more or less utilitarian common household object. It will elicit only the mildest of emotions in keeping with the beauty and utility. For a patient with a hysteric personality structure, the same object may suggest female genitalia and produce a fascination, a desire to handle, and overt evidence of emotional or sexual excitement. For an individual with an obsessive character, the clay and the shape may provoke anal associations. He may then be inclined to mold and remold the clay "obsessively." The alternative would be a reaction against this impulse, making him unable to touch and handle the clay. A regressed schizophrenic may find in the same product a uterine symbol producing a peaceful, calm experience associated with the enclosing, protective, comfortable state of inaction symbolized by it.

Although we can seldom be sure of a patient's subjective experience, the foregoing considerations give us a basis for an educated guess that can then be proved by repeated observations. For any specific patient, incidental and fortuitous past experiences may lead to contrary emotional reactions, but these cannot be anticipated without knowledge of those past experiences. For instance, if an activity has been previously used for gainful employment, it may have much greater value as an ego support than if it had never been so

used. On the other hand, if it is an activity that was enjoyed in the company of the mother at a young age, it will have a more basic emotional gratification. If it has been previously used under duress or during a particularly unhappy experience, such as a bout of homesickness at summer camp, it will be unexpectedly anxiety-provoking to the patient.

In order to make full use of activities, then, it is necessary to understand something of the object-relations potential of the patient as well as the symbolic significance of the materials used and the emotional quality of the action required.

REFERENCES

ALLPORT, GORDEN W.: *Becoming: Basic Considerations for a Psychology of Personality.* New Haven: Yale University Press, 1955.

ERIKSON, ERIK: "The Problem of Ego Identity," *Identity and Anxiety: Survival of the Person in Mass Society.* Glencoe, Ill.: The Free Press, 1960.

PHILLIPSON, HERBERT: *The Object Relations Technique.* New York: Robert Brunner & Co., 1961.

SARVIS, MARY A., and GARCIA, BLANCH: "Etiological Variables in Autism," *Psychiatry,* Vol. 14, No. 4, 1961.

SCOTT, CLIFFORD W.: "The Body Scheme in Psychotherapy," *Brit. J. M. Psychol.,* Vol. 22, No. 3–4, 1949.

CHAPTER 4

The Dyadic Relationship

Individual personal relationships are undoubtedly the single most important factor in any effort to help another human being. Even in those instances where clear-cut physical or chemical procedures are involved, there is no doubt that the effectiveness of these procedures is significantly influenced by the emotional atmosphere and the nature of the total set of attitudes and expectancies that the patient holds for the therapist. Many individual instances have been noted, and a few more systematic studies have reported that a person undergoing surgery for relatively simple pathology may nevertheless have a prolonged recovery if he is being neglected by surgeon or family or if he is being irritated by nursing care or economic problems.

In caring for people whose disorder is psychologic, this personal relationship not only produces a bias in the effectiveness of other procedures but is of central importance. We have come to acknowledge this by referring to many of the new pharmacologic agents in terms of their ability to "improve the therapeutic relationship."

A personal relationship of some kind must of necessity exist where two individuals deal with each other. The specifically professional aspects of these relationships and the efforts to improve their usefulness have been referred to and studied as the "therapeutic relationship" or the "therapeutic use of the self." The key issue, of course, is to perceive the action on the part of the therapist that will be helpful or therapeutic to the patient under consideration in contrast to those actions that will be of indifferent significance or disruptive to the patient. To be completely effective in perceiving these differences is a goal but not a literal expectation. It is doubtful that anyone can completely perceive all the significant or potentially significant possibilities in a relationship with another person. We can, however, greatly improve our effectiveness by attention to the basic understanding of human relationships.

The therapeutic dyad is built on the basic human characteristics found in both partners of this helping relationship. Which characteristics will be considered of major importance depend on the understanding and the emotional bias of the therapist. Those who share similar convictions about this are likely to become identified with a so-called school of psychoanalytic thought. For our purposes, it is useful to review some of the basic issues.

Every person has to come to terms with several emotional issues simultaneously in each relationship that confronts him. There is a problem of dependency, which probably is related to man's gregarious nature and his limited ability to cope with life during infancy and childhood. Each person must be at ease with himself as to how dependent he may be, but to finally achieve this state requires complementary behavior on the part of the other person. The patient may

be just enough aware of his own difficulties to feel quite helpless and in need of active support from the therapist. If this expectation is not fulfilled, he will react in a manner that will depend on other personal strengths and characteristics. For instance, if he is a relatively strong person, he may re-evaluate his own expectation and find that he is after all not so completely devoid of assets for self-reliance. If, in contrast, he does not have this degree of self-confidence, he may conclude that there must be a badness within him that makes other people neglect him in his obvious need. A third alternative is that he will simply get angry at the therapist in response to the frustration experienced.

Aggressiveness is likewise a basic issue for each person to handle to his own satisfaction. Aggressiveness arises from several related sources. Frustration of our efforts to achieve gratification is one important source. The innate characteristic of a carnivorous being can account for some of our need to be aggressive and destructive. A third source of aggressiveness is the individual's need to establish a status relationship with those about him. Everyone has a different need for power, and various avenues are available for us to achieve it. Each of these sources has its aggressive aspects and may be at times expressed more in terms of destruction of the other person and less in terms of increasing the status of the self. Once again, the satisfaction of these aggressive urges requires some degree of complementary behavior on the part of the other person.

The problem in therapy is to anticipate the degree and type of response that will help the patient. When the patient is pathologically involved in repressing any experience or expression of aggression, the therapist may help find a constructive activity with which to be aggressive. When

his control mechanisms are deficient, the same activity may be offered by the therapist to help channel the behavior in constructive directions. On some occasions, the therapist is the object of the patient's aggressive drives, in which case he must avoid the trap of responding in an aggressive manner without considering the usefulness of this aggression to the patient. For instance, if the patient needs increased control of his aggressiveness, he may achieve this better by identifying with a well-controlled therapist than by trying to win an aggressive struggle between them. A different patient, however, will be grateful for the counteraggression, which can be an outside support in helping him to control himself.

A third problem with which everyone must cope is the achievement of gratification. Certainly the gratifications of thirst, hunger, and temperature needs are basic, and yet for modern man they seldom present serious problems. On the other hand, the achievement of interpersonal gratification from the combined opportunity and ability to develop a warm, reciprocal relationship is of more far-reaching emotional significance and seems to have the same chance of failure in current society as it had in any past era. The most significant aspect of this interpersonal gratification is the sexual one, and it is in this area that many problems of human relatedness become most dramatic.

Here again no single reaction from the therapist will be helpful to every patient. In one instance the patient who has little facility for emotional interaction may be aided by some mildly seductive behavior in the therapist. At the opposite extreme, another patient may be quite seductive, and the therapist may be required to make a special effort

to remain involved on a professional basis rather than a personal or sexual one.

A fourth problem is created by the desire to achieve and maintain a sense of personal completeness and integrity. This involves such basic notions as the body image that each person forms about himself. There are many ways of demonstrating that people with physical disabilities can have emotional difficulties in reconciling themselves to their new body image. It is also true that in many emotional disturbances, the patient will be found to have a distorted concept of his own physical structure. In more subtle ways, each human being also must achieve a relatively realistic evaluation of his own potentialities, strengths, and weaknesses in dealing with other people. This awareness of the self develops gradually in the life of the individual. The newborn infant presumably has no concept whatsoever of the difference between himself and his environment. Most parents observe at one time or another the surprise that an infant shows in discovering his own fingers or toes and finding that there is an organic connection between them. Gradually, over the next period of years, the child tests and learns the limitations of many different faculties. It is often not until puberty or adolescence, however, that a person achieves a full sense of self-awareness. Prior to that time the child is inclined to feel that he is part of a family or clan or human community with qualities of eternal life and unlimited potential. Once the psychologic and physiologic changes of adolescence occur, the person becomes aware of himself as a unique being with vulnerabilities and limitations built into his being.

The list of qualities and limitations and potentials that,

in fact, exist for all of us is quite endless. Each person is likely, however, to be somewhat selective about the particular qualities that concern him. For instance, one person may be very much aware of his own physical characteristics and be less concerned about his economic status. If he were to lose his leg in an accident, he might feel that his worth as a person was almost completely destroyed, despite the fact that this did not appreciably interfere with his social or his economic possibilities. However, another person, who has more investment in his social status and is relatively inattentive to his physical qualities, might take the same accident with much greater equanimity. The ways in which these issues can become manifest in the relationship between therapist and patient are quite numerous. They do play an important part in determining the subject matter of conversation or the nature of the product that is made or the facet of the occupational therapy situation that has greatest impact on the patient. For instance, the patient whose sense of worth is closely tied to his social status will be more responsive to group activities and group pressures than to the product or materials involved. Another patient, who feels that his value lies in his ability to be creative, may be comparatively oblivious to the social characteristics of the situation as compared with the quality of the materials and his ability to express inner emotional states with them.

On the basis of such elementary human characteristics in both the patient and the therapist, they develop a two-person treatment relationship. Each makes some accommodation to the needs of the other, but each is only partly aware of the factors involved. No one is fully aware of his own characteristics or those of others. Generally this situation is described by saying that each person in the interaction consists of three

selves. First of these is the hypothetic real self, which is, in fact, interacting with the other person. The second is the individual's perceived self, which differs by being incomplete and in most instances inaccurate. It may be incomplete because the person chooses to ignore those aspects of himself that displease him. It also may be inaccurate because the person perceives qualities in himself that he wishes were there but are not. The third self is the one perceived by the other person, and this may be chiefly characterized by being incomplete, but it may also be inaccurate when there is an emotional involvement that distorts the perception. Each of these three selves is present for both persons, and this helps to complicate the problem of trying to understand what is really happening in the interchange.

The therapist is the one who must spend the greatest effort in trying to reconcile the various distortions involved—first, in an effort to be as realistic as possible about the patient's concept of himself and, second, to define the differences between the patient's concept of himself and the patient's real self.

The effort to achieve this requires empathy on the part of the therapist. It is the kind of understanding that is designated when a person says of another, "He understands me." It involves in one degree or another an effort to imagine oneself in the position of the patient. It has been noted that the severely disorganized statements of a schizophrenic patient can become comprehensible once the observer becomes aware of the assumptions the patient is making about himself and his life. This is the process of putting oneself in the place of the patient, which leads to an understanding of his perception of himself, which can then be compared with a more realistic perception of him.

The meaning of behavior is further modified by the reality situation in which the two people meet. The concept of role playing is an important and ever-present one in all our human dealings. It is this that leads to statements such as "A doctor wouldn't do anything like that." Or in a more positive sense, we might state of a particular act that it is "just what a friend would do." Unfortunately, the roles people play are subject to change without notice. The patient has his idea of what an occupational therapist does, but new information will change his expectation and therefore alter his behavior.

Aside from the personal idiosyncrasies of role characteristics, there are some rather definite role specifications for a patient as well as for a therapist. Having an expectation of how a patient should behave is of benefit in setting up the relationship originally because it gives each individual a base line of behavior, so that each can be relatively comfortable or at least feel able to defend himself from the threats involved. On the other hand, this can sometimes produce problems of its own, such as occurs when the therapist expects "crazy" behavior from a patient and then proceeds to behave in a way that encourages such behavior. In contrast, it is possible to maintain integrity as a therapist while at the same time encouraging and anticipating normal behavior from the patient.

Up to this point we have been defining the situations and the processes that are important in understanding the relationship between patient and therapist. Before turning our attention more fully to the problems of the therapist himself, it will be of value to look at some of the ways in which patients will avoid change and manage to maintain their pa-

thology in spite of the intention of both therapist and patient to improve the situation.

Basically, of course, all the mental mechanisms that are used to produce the pathology in the first place will undoubtedly be continued in the service of maintaining that pathology. This can be taken as a basic assumption in every treatment situation. In addition to these mechanisms, there are other possibilities that we should always have in mind. For instance, avoidance or selective inattention may be used with considerable success in keeping very important considerations unexplored. It is worthwhile from time to time to ask the question of whether there is something noticeably missing in the behavior or comments of a particular patient. In psychotherapy the observation may be made after a number of months of treatment that the brother of the patient has never been mentioned. Questioning these omissions often reveals important information. It is possible that comparable discrepancies can be observed in occupational therapy. For instance, one patient may share activities with a patient friend while working on two or three projects but become inactive or go his own way when the friend turns to a fourth activity. Although such a change could be the result of numerous factors, it may reveal a specific emotional involvement with the project in question.

In contrast to hiding a particular problem by never referring to it, it is also possible to hide a problem as one would hide a tree. This would be to place it in a forest. In such a maneuver, the patient will overwhelm the therapist with so many problems of major and minor importance that the problem of basic significance is lost. A concerted effort to evaluate all the issues is necessary, of course.

Another manner in which a patient resists change is based in the depths of his very conviction that he has a difficulty. The conviction itself helps to prove the difficulty. For instance, a person may be apprehensive about appearing on the stage but finds that, once he is in that spot, he is able to function well and get satisfaction from his role. Another person, who has a more deep-seated conviction about his inability, however, may find that he breaks into a sweat that so preoccupies him that he cannot function well. In this sense one is often caught up in what is described as a self-fulfilling prophecy. In many instances this will work to a person's advantage, but one must guard against the patient's perpetuating his difficulties in occupational therapy or other aspects of living because of his prior conviction.

Another mechanism that often obstructs the treatment process is the diversion of the therapist's attention from the task at hand. This is most often accomplished by some form of attack on the therapist, but it may also be done by personal gratification of the therapist. The ability of an emotionally disturbed person to sense the insecurities and sensitive spots in the people around him has been demonstrated many times. It may be by taking note of particular physical characteristics or by commenting on aspects of the therapist's personal life or general attitudes. Each of these may preoccupy the therapist with his own sensitive spots to the extent that he cannot adequately be concerned about the patient. Usually the defensiveness of the therapist is not immediately obvious and is revealed in review of the case with a supervisor or in staff discussion of the treatment of the patient. The frequency of such problems depends on the degree of self-awareness of the therapist and his readiness to evaluate objectively every facet of his own personality.

There are many ways in which a patient may gratify the therapist to his own detriment. For instance, if the therapist likes to be helpful and mothering, he may be much pleased by a helpless patient who continues to behave in a helpless manner. Likewise, often the therapist has gone into the helping professions because he feels comfortable in dealing with people who are demonstrably inferior to himself. This may mean that the patient must remain limited in some manner in order to preserve a satisfactory relationship with the therapist. A specific example may help clarify the subtlety with which the gratification of the therapist may interfere.

A therapist in a mental hospital became interested in a withdrawn, catatonic patient who had been hospitalized for many years. Her own professional growth and the desire to tackle more serious problems, as well as her intuitive response to this man as a potentially productive and happy person, led her to choose him for intensive work. In the course of many contacts during which he became involved in several kinds of activities, it was discovered that he had an appreciable talent for art. With this as a focal point for their relationship, the patient continued to improve remarkably to the extent that he became very attentive to his dress and to his eating and hygiene habits, while at the same time becoming much more sociable with patients and personnel alike. His ability was such that he managed in several months to have a one-man show of his art in a community art gallery. While things were going very well with him, the therapist received some visitors at the hospital and in the process showed them the paintings of this patient but did not involve the patient in the discussion or in any way bring him into contact with the visitors. When the therapist came to the hospital the following day, all the paintings had been

destroyed, and the patient was sitting in the corner of the ward in his pajamas once again. It seemed clear enough in this instance that the therapist was gratified by the productivity of her patient rather than by the patient himself, and when this was demonstrated so graphically to him, he quickly retreated to his old pattern of withdrawal.

Most of the factors we have considered to this point have been of a basically individual nature, either as the problems or potentialities of the patient on the one hand or as those of the therapist on the other. We should also deal with some of the concepts that have been formulated to understand the rapport or the cement that holds the relationship. There are primarily three terms of concern. They are rapport, transference, and countertransference. A brief definition will suffice to indicate the general issues involved, although each treatment situation must be constantly re-evaluated to define the many variations in transference and countertransference that cross the scene in ever-changing patterns.

Rapport has been achieved when the interchange between people has led to an expectation of positive interest and good intentions toward each other. This is a product of some very realistic factors in the situation, such as the physical setting in which patient and therapist meet. It is also influenced greatly by the staff whom the therapist represents and the apparent status of the therapist with that staff. But more important, it is influenced by the positive show of interest and response to the personal communications of the patient. One crude measure of rapport may be evidenced by the ability of the therapist to say of the patient, "Now I feel that I know him." On the patient's side, it might more importantly be expressed as, "Now I feel I can trust him."

In contrast to this basically realistic side of the forma-

tion of a relationship, we are also confronted with transference, which is expressed as the reaction to another person based on past relationships rather than on the realistic observation of the present one. If the patient has a clearly defined set of attitudes toward his mother and reacts to the therapist as though he had the qualities of the patient's mother, to this extent he is manifesting a transference reaction. It is not always clear that a given reaction is transference, and the therapist must always be free to decide whether a patient's accusation is justified or whether it is a transference phenomenon. The appropriate reaction is, of course, quite different in the two situations. At the time the patient is being given materials or instruction, he may respond as he would toward his mother on the basis of this giving relationship. However, at the point where limitations are set on his activity or behavior, he may respond with feelings that are more appropriate to his father. At times this change in the patient is quite noteworthy and often puzzles the therapist, who cannot account for the shift.

Countertransference is a problem of somewhat more subtle proportions and may be defined as the unconscious reaction of the therapist to the transference behavior of the patient. This is somewhat separate from the instance where the therapist responds to the patient as though the patient were a father or brother. Such transference phenomena on the part of the therapist are also possible, and they do undoubtedly occur. However, a countertransference is an unconscious compliance with the expectation of the patient to the extent of behaving like the person he perceives the therapist to be. One may for instance find oneself giving an unusual amount of instruction to a patient who may reveal

that he is annoyed at being treated as an incompetent child as his mother treated him. One will then realize that the unusual amount of assistance was given in response to the patient's clear expectation that he was dealing with just another mother.

With so many variables to consider in each treatment situation, it would certainly seem impossible to find any technique that would be always effective. It is our impression that no simple list of do's and don't's will be of any appreciable benefit, but on the other hand there are certainly some basic considerations that can be applied at all times. They will be applied more effectively as training and experience increase.

To be clear as to what is involved in the therapist's behavior, we would like to emphasize that every facet of the personality of the therapist is potentially involved in the treatment relationship. This does not mean that every aspect is of importance in every case, but it is potentially important with one or another patient. This would seem to suggest that a therapist would need to be perfect in order to avoid running into trouble with some patients. Obviously, there are no such therapists, and fortunately this is not a necessity. We are fortunate in that all patients are able to cope with some biases in the people who try to help them. Also, it is possible to correct difficulties of this kind if the therapist is willing and able to perceive them after they occur, even when he did not anticipate the difficulty or prevent it.

We cannot pass such limitations off as having no influence on treatment, however, because in a practical sense each therapist is likely to find at the beginning of his career that there are some kinds of patients whom he treats with greater

facility and with greater success and others whom he would best avoid because of the problems that arise and his failure to be of substantial help to them. With an increase in training and experience, one can expect to enlarge the variety of patients with whom one will be comfortable and helpful. Even with a great deal of training and experience, each therapist retains a personality of his own, and this must necessarily influence in some minimal degree the ease or difficulty in dealing with different patients.

The fact that one does manifest a recognizable personality is quite helpful in forming a relationship with a patient at the start. If we take this indication too literally, however, and say that the objective is to "be yourself" or to just act naturally, we will find this is not so simple. Certainly the patient will respond well if the therapist is as "human" as possible, but on the other hand, if the therapist becomes completely devoted to acting spontaneously, it is likely that his own personal pathology will distort the relationship, and he will excuse this by saying that he is supposed to just be himself.

Should the therapist really become involved, enthusiastic, or devoted to his patient treatment? Certainly if he does so, this will impart a vitality to the relationship and produce the kind of expectation that in itself can be very healing. For example, the placebo effect, which has been known for centuries, is possible because the patient responds to the interest and good intention of the therapist in giving him the inert medication. It has been demonstrated many times that very real physical changes have followed when the patient was sincerely led to expect them. If, however, the therapist becomes more enthusiastic about his treatment technique

than about the patient, this may be perceived by the patient, and the therapy may end up being quite ineffective or even detrimental.

A closely related consideration is the question of how easily the therapist plays the role to which he is assigned. If he behaves as a therapist with a feeling of confidence, this in itself is likely to be helpful to the patient. Similarly, if the therapist manifests a confidence that the patient will be helped, this also can be reassuring.

The reassurance that results from this air of confidence on the part of the therapist is, however, not easy to pretend with any chance of success. This is partly based on the fact that pretense of any kind is generally hard to maintain, but also partly on the fact that reassurance is achieved by different means in different people. For instance, to praise one patient for what he produced may be very reassuring to him and encourage him to take greater initiative for himself. Another patient may feel that praise is only a trap leading to further demands on him, and he will doubt its sincerity. In contrast, in some instances it is helpful to a patient if the therapist gets angry at him, because it reassures him that the therapist really takes him seriously. Since many occurrences can provoke irritation in the therapist, it is probably helpful to express some of these irritations, as long as the over-all contact with the patient is motivated by a helpful intention toward him. This can be compared to the case of a child who can benefit from a spanking as long as he knows that his parents are really interested in his welfare.

Another requisite for being helpful to the patient is knowing a reasonable amount about the patient's history so that one may have the feeling of understanding his present predicament. Along with this there should be a body of knowl-

edge about normal human development as a comparison. With this knowledge it is easier to react constructively to the regressive behavior of the patient and to the limitation in his ability to relate to the therapist.

Since there are many unknown quantities in a therapeutic relationship, and since there are likely to be many highly emotional incidents, it is helpful for a therapist to have a high tolerance for anxiety. At the same time that one has this tolerance, however, one should be constantly inspecting one's own feelings to learn more about one's own behavior and reactions, which in turn will reduce the level of anxiety. As long as this process continues, the therapist will continue to grow.

REFERENCES

ALEXANDER, FRANZ: *Psychoanalysis and Psychotherapy*. New York: W. W. Norton & Co., Inc., 1956.

ROBINSON, GEORGE CANBY: *The Patient as a Person: A Study of the Social Aspects of Illness*. Chicago: University of Chicago Press, 1954.

SULLIVAN, HARRY STACK: *The Interpersonal Theory of Psychiatry*. New York: W. W. Norton & Co., Inc., 1953.

———: *Toward Therapeutic Care*. New York: Group for the Advancement of Psychiatry, 1960.

———: *Therapeutic Use of the Self*. New York: Group for the Advancement of Psychiatry, Report 33, 1954.

WHITAKER, CARL A., and MALONE, THOMAS P.: *The Roots of Psychotherapy*. New York: The Blakiston Co., 1953.

WYLIE, RUTH C.: *The Self Concept*. New York: Robert Brunner & Co., 1961.

CHAPTER 5

Group Phenomena in Occupational Therapy

The importance of group relationships in occupational therapy is reflected in more than the simple phenomenon of treating several patients at the same time. Current trends in social psychiatry have brought attention to many different kinds of group contacts, and each of them has been found to be a potential factor in the production of pathology. With proper understanding and an opportunity to modify the group, it can become an equally significant potential factor in therapy as well.

The occupational therapist cannot avoid group participation any more than patients or other staff members can avoid it. He will find himself automatically functioning in at least three groups and having a different group relationship in each. In activities with patients, the occupational therapist is a group leader with responsibilities toward developing the emotional atmosphere of the group. It is he who makes the greatest contribution to the kind of expecta-

tions developed by the patients and to the general control of group behavior. In a different setting, the occupational therapist is part of a group of peers with whom he shares responsibilities toward mutual problem solving and the development of professional competence. With the other medical staff, he is a team member with responsibility toward making the potential of his own contributions known and, therefore, usable. It is also important to know enough about the functions of other team members to make use of their knowledge, competence, and assistance when this is indicated. The awareness of the variety of groups and the variety of roles within groups opens up the possibility in each case of enhancing effectiveness in this aspect of professional functioning.

The role of leadership in the patient group has an especial importance because of the immediate evidence of response from the patient. This response is frequently direct and is reflected in the attitude of the group as a whole and the general level of cohesiveness. These general group attitudes make more of an impression on the therapist when he is aware of responsibility for them. A change in one's own behavior has a more immediate impact on the entire group when one is in the role of leader. It is in this situation that the occupational therapist can learn most about the evolution and progress of the group as well as the progress of the individual patient. To evaluate this process requires a set of assumptions about what constitutes a desired group goal and a basic knowledge of group dynamics to help facilitate that desired development.

If it can be assumed that one of the principal aims is to have patients express and find gratification for their individual anxieties in some measure, the group must become suf-

ficiently comfortable and free of strictures to permit this. If one assumes that another aim is to prevent individual anxieties from becoming disruptive, one must be prepared to allay that anxiety and minimize its spread to other group members when tension in one person or a total group mounts too high. The measure of whether tension is indeed too high generally resides in the occupational therapist himself, who may be able to tolerate and work constructively with higher levels of tension in some instances more than in others. Individual differences and differences in feeling of competence will influence how much anxiety is tolerable.

From the patient's point of view, the initial problem is to learn how to relate to the new situation in occupational therapy, which may include a new group of people, if he has not had other experiences with these persons. The first issue, then, in bringing a patient into a group is to help him achieve the feeling of knowing enough about the other patients and knowing enough about the purpose of being together so that he may feel as much at ease as the situation allows. With the better-integrated patients, a single introduction is at times sufficient. With more disorganized and confused patients, it may be necessary to define an activity in which they will be involved before approaching the more threatening experience of contact with other people. For instance, if a new patient is led to a table with material placed on it, he may be relieved of the anxiety of watching what other patients do or of making a choice among several possibilities. This can put him at ease and allow him to make contact with other people at his own pace. A more aggressive patient, however, may find that this procedure is too restricting and prevents him from having a chance to know the other people present before finding his "place in the

group." In either case, the patient is trying to become familiar with the situation and to find if it is safe for him to express himself. At this stage of the relationship, the therapist should avoid attempts at having the patient express his personal anxieties before some feeling of safety has been achieved. During this process of orientation, the therapist will need to be aware of the variety of ways in which people test out new situations. One of the commonest procedures is to express anger and criticism. This may be directed at the therapist or at the occupational therapy situation or may be more indirectly evident in complaints about the institution or society in general. The therapist may feel defensive about such comments and, in the effort to set the patient straight, may teach that these expressions of personal attitude are not encouraged. On the other hand, the therapist may feel discontented and insecure himself, in which case he might encourage the complaints and divert attention away from more pertinent issues.

It follows then that one of the signs that a patient or group has moved past the initial feelings of strangeness and suspicion is increasing readiness to reveal personal interest and concern. In conversation this may be manifested by the patients' telling their ideas of what has produced their symptoms. In behavior, it may be manifested by an increasing willingness to choose among available activities. In the activity itself, it may be manifested by an increased readiness to be creative and original. The product of the patient's activity at such a time is generally of considerable diagnostic value. This period of expressiveness may be viewed as the second stage in the evolution of the patient's relationship to the group. It is likely that his awareness of other people as individuals is still quite limited and evident principally in

regard to the therapist. At this point an increased show of approval will encourage the personal revelations of the patient with the effect of enhancing his emotional investment and of increasing the amount of diagnostic material available. To encourage the reaction of one patient to another while they are talking about personal issues will facilitate the development of a group's spirit.

Once the various members of the group are assured that this is a safe place and that they have been able to express themselves with some freedom, an increasing awareness of the other patients and an attempt to respond to them usually follow. This can be considered a third phase in the evolution of the patient's relationship to the group. At this point, the therapist can capitalize on the mutual awareness by proposing joint projects and cooperative enterprises. In some instances, the whole group may be involved in one project, or in other instances a better-integrated patient can be of help to himself by also helping one of the more poorly organized patients. To the extent that the various patients do become aware of each other, this may now become a group in the subjective experience of each member. The turning point is often very clear when the various individuals present feel that there is now a group in contrast to the previous mixture of individuals. The achievement of this amount of mutual awareness can be intuitively experienced by each member, including the therapist. Out of this grow a desire to be of help to other group members and a sense of self-control based on respect for the rights of others. The therapist himself as an agent for change is then augmented by other patients who are also being helpful in varying degrees. Patients feel a very real emotional support from that elusive entity, the group-as-a-whole. This does not mean that the

therapist becomes less important, but rather that he now has additional factors to use in planning for the welfare of the patient.

By the time a group has achieved a significant level of integration, the various individuals have come to share an expectation of what may be done and expressed and achieved within the situation. As in all other human experiences, each individual will have his own interpretation of the group's standards because of his own needs and past experiences. Because this occupational therapy group has a leader with authority and one who has the interest of group members as an objective, there is every likelihood that family relationships will be interpreted into this situation. Other patients will at times evoke the competition accorded to siblings, and the therapist may prompt a set of attitudes previously felt toward parents. There will be disagreements between patients that can be understood as the struggle for favor with the therapist. At the same time, the high productivity of one patient may be the sign of silent competitiveness, which is based on the same struggle for favor despite its overt difference in form. In this way the characteristics of the group may be influenced by the transference phenomena.

The behavior of the therapist will also be a factor in establishing group characteristics. Should the therapist make most of the decisions about the various activities and deal with the patients only on an individual basis, he then minimizes the impact of one patient on another and reduces the amount of information achieved. This approach will allow one to make most use of inspiration or suggestion as therapeutic tools. This may be the most fruitful group structure when the patients are highly disorganized and unable to decide for themselves and to assume an interest in each other. At other times the

therapist can relinquish the responsibility of firm leadership and even allow patients to assume leadership of the group when this competence is demonstrated and when the patients are able to deal with each other as individuals. This opportunity to assume responsibility and leadership and to again relinquish it is an experience that can be most helpful to the patient. A good group as measured by its therapeutic value is not likely to be the same as a good group as measured by its productivity or by its manifest self-control or by its unity of purpose. It must be measured rather by its ability to afford a patient a chance to attempt and to achieve new behavior patterns that are constructive and rewarding.

The leadership activities are also modified by transference phenomena. For instance, if the therapist is aware of the competitiveness between individuals, he may focus attention on one patient in order to provoke a competitive reaction from another individual who seems less approachable or who shows promise of being more constructive under this stimulus. He may discover, on the other hand, that his attention to one patient produces a reaction of feeling rejected, leading to withdrawal or destructive behavior in a different patient. The most helpful choice can be made only when the leader is aware of this type of reaction.

Beyond the direct personal issues involved in developing a therapeutic atmosphere in occupational therapy, other influences are derived from the setting in which the treatment is undertaken. By proper arrangement of space and equipment, those engaged in a single kind of activity can be together and be spatially separated from others involved in different activities. Space arrangement may, on the other hand, produce a maximum amount of contact between patients and thereby encourage more group interaction. This

effect of the physical setting is further modified by the institutional atmosphere, which predisposes the patient to expect a more or less authoritarian atmosphere or to expect encouragement or discouragement of patient interaction. The ability of the individual therapist to control these factors is, of course, minimal in most instances. On the other hand, there are occasions when an improvement can be achieved if the therapist is aware of what is desired for his purposes and communicates this to the proper people.

Up to this point we have given no consideration to the size of the group, which also has an effect on group function. If a small group is in a large space, there is an atmosphere of isolation and loneliness, which tempts people to communicate less. Overcrowding, on the other hand, is likely to increase interaction but increase interference of one patient with the other. Irritation is more apt to be generated. Each space might be viewed as having an optimal group size leading to an optimal amount of contact and interchange between patients.

Although the room sets limits of its own, the type of activity in which the patients engage may lend itself to large group cohesiveness or to the development of subgroups. One's choice of which to encourage will depend on the degree to which the given patients are capable of cooperative effort and how well this cooperative effort coordinates with the treatment aims of the staff of the institution.

Regardless of how the group function evolves over time or how the therapist guides that evolution, the effectiveness is still measured in terms of its benefit to the individual patient. Evaluation of an occupational therapy program by the quality of the product made by one or more groups takes attention away from the primary purpose, which is the treat-

ment of the patient. Likewise, a preoccupation with group loyalty or effective cooperation between members may lead the therapist to ignore issues that are more pertinent at the moment. Fortunately, within a given group structure opportunities arise for several different roles to develop, so that the variety of individual needs can be met simultaneously.

The brief time of meeting and the relatively standardized conditions of most occupational therapy tend to obscure some of the rich variety of roles that people can assume to cope with their own emotional needs. A thorough exploration of these possibilities is beyond the scope of this book or, indeed, of occupational therapy itself. Nevertheless, a brief indication of some of the areas of study that involve group functioning and role playing may give some idea of the potential usefulness of study in this field. Perhaps anthropology has been attentive to the largest groups and has revealed the rich variety of patterns of living that can be adequate and adaptive if they fit the circumstances. One conjecture that has frequently been made on the basis of anthropologic studies is that one type of behavior may be considered adequate or even preferable in one society, whereas the same behavior is considered insane in another. From this and other observations we must conclude that one measure of healthy behavior is that it should fit into the value systems and the expectations of the other people with whom one must deal. This aspect of our evaluation of patients is more or less taken for granted when one deals with patients from one's own culture. One is more likely to become aware of it, however, as one deals with people from a different culture and heritage.

At a level that comes closer to everyday experience, so-

ciologists have been studying community groups, their methods of communication, their organizational structure, and the types of tasks they perform. At this level it is occasionally possible to see quite clearly the effect that his role in a group has on the emotional health of a given individual. As just one instance, a good, competent worker may find the role of assistant manager or assistant superintendent quite congenial but will develop crippling obsessive or depressive symptoms when promotion changes the role requirements to those of manager or superintendent. Here again, the individual reveals the dependence of his mental health on the group setting in which he needs to function and on the role he can achieve in that group.

In recent years, attention has been focused on the mental hospital as a unit for sociologic study. Evidence of power and status relationships has been demonstrated in clothing, type of communication, character of humor, and other processes. In *The Mental Hospital* [1] and other subsequent studies there are demonstrations of how these communication patterns become reflected in the increase or decrease of symptomatology in the patient. The patient has a role to play in the hospital community, and this role may meet a variety of responses from an uncoordinated staff with a resulting confusion and anxiety. In terms of one's own job, this means that if the goals and ambitions of the occupational therapist are in accord with those of the nursing and medical staff, the patient will benefit from the consistency. If one's objectives are not compatible with those of the rest of the staff, this will be reflected in difficulties with the patients.

[1] Stanton, Alfred H., and Schwartz, Morris S.: *The Mental Hospital: A Study in Institutional Participation in Psychiatric Illness and Treatment.* New York: Basic Books, Inc., 1954.

In order to achieve the kind of coordination that is desirable with the rest of the staff, it is necessary first of all that each member understand the other. As a member of the staff group, the occupational therapist shares a responsibility that goes beyond just accepting the direction of the leader. When the occupational therapist can understand the objectives of the team leader, there will undoubtedly be times when he can suggest ways of implementing these objectives of which the psychiatrist is unaware. Familiarity with psychiatric and psychologic terms and concepts of psychotherapy will aid this process immeasurably. On the other hand, it is just as important for other team members to be learning about the methods and concepts of occupational therapy. This can be achieved in most cases only by having active participation of and discussion with the occupational therapist. The contributions of occupational therapy to patient care must be stated. The cohesiveness and mutual respect that then develop in the staff as a group will set the stage for tolerance and respect of patients also.

We could not cover all the contributions made in the field of group process without giving attention to the family. Although in many instances the occupational therapist is not involved with the families of hospitalized patients, it is still helpful in understanding patient behavior in a group to know something of the patients' behavior in their families. A familiarity with concepts of family therapy will also emphasize the usefulness of complementary roles in achieving group cohesion. Most patient groups and even social groups have an acknowledged similarity among their members and can identify with each other as individuals. Within the family, each member has very distinct characteristics and roles, but each person with his different interests can find gratifica-

tion within the unit, and the group will endure. For instance, one's occupational therapy group can contain a dependent individual who is put at ease by a more aggressive patient who readily makes constructive suggestions. Many other such complementary combinations can be noticed once one begins to look for them.

Probably the best organized and most pertinent body of information about group processes is to be found in the field of group psychotherapy. The group psychotherapists have worked with groups comparable to ones with which the occupational therapist is involved. Both the study of individual patients who have been treated in groups and the study of group characteristics with patients of various diagnoses will afford material for use. Efforts at using the group constructively will include attempts to increase the mutual awareness and interchange between patients. It should be pointed out, however, that the use of group psychotherapy techniques should be limited by the therapist's prior knowledge of and competence in individual psychotherapy.

Since each of the fields of study pertinent to understanding and using group interaction is a basis for separate professional study, the occupational therapist will certainly not need to be expert in them. However, since he does in fact work with groups of patients, he can improve his effectiveness by reading and direct contact with these fields. Such knowledge will also help one to know where to turn in seeking understanding of problems that confront one in patient groups.

REFERENCES

BION, W. R.: *Experience in Groups.* New York: Robert Brunner & Co., 1961.

FESTINGER, LEON; SCHACHTER, STANLEY; and BACK, KURT: *Social Pressures in Informal Groups.* New York: Harper & Bros., 1950.

HOMANS, GEORGE C.: *The Human Group.* New York: Harcourt, Brace & Co., 1950.

SCHEIDLINGER, SAUL: *Psychoanalysis and Group Behavior.* New York: W. W. Norton & Co., Inc., 1952.

SLAVSON, S. R.: *Introduction to Group Therapy.* New York: International Universities Press, Inc., 1957.

SMITH, MARION R., BRYANT, JOHN, and TWITCHELL-ALLEN, DORIS: "Sociometric Changes in a Group of Adult Psychotics following an Intensive Socializing Program," *Group Psychotherapy,* Vol. 4, No. 4, 1951.

THIBAUT, JOHN W., and KELLEY, HAROLD H.: *The Social Psychology of Groups.* New York: John Wiley & Sons, Inc., 1959.

WILMER, HARRY A.: *Social Psychiatry in Action: A Therapeutic Community.* Springfield, Ill.: Charles C Thomas, 1958.

CHAPTER 6

The Meaning of Activities

Increased emphasis on the significance of the interpersonal relationship in the treatment of the mentally ill has impinged considerably on the concepts and practices of occupational therapy. Examination of both literature and clinical practice over the years certainly indicates an increasing awareness of and concern for the therapeutic relationship, or the "use of self" in treatment. Concurrent with this focus of interest one perceives a diminution of investment in "the activity" in occupational therapy, i.e., the end product of the art or craft. Such development has at times been perceived as a conflict between the importance of the activity and the importance of the interpersonal relationship. Certainly the single factor that may be considered to constitute the uniqueness of occupational therapy is the use of activities or objects. However, we would see any dichotomy as more apparent than real. If we can accept a definition of psychiatric occupational therapy as the use of the psychodynamics of activities and the concomitant relationship, one may be-

gin to see the interrelationship and perhaps more clearly discern the dimensions of each.

Interpersonal relationships are influenced by many factors. Within the psychotherapeutic frame of reference, the more influential ones have been identified as the patient, the therapist, and the group. Interaction in these areas constitutes an experience unique to a given setting and to its component parts. Occupational therapy utilizes an additional component in the form of an activity or object. The influence or impact of this component on the others then comprises the occupational therapy experience, which is unique to this setting and to the combination of these components. Such a description indicates the interdependence of each component and their essential and equal value. Thus to state that the use of activities is the distinguishing characteristic of occupational therapy should in no way imply that this in itself has greater value than the other factors, since each is essential to the total experience. This concept then points up the importance of a thorough understanding of each component of the occupational therapy experience in order that we become more skillful in their use.

An hypothesis exists that since action is the natural antidote for anxiety, any action or activity will relieve anxiety. It has further been hypothesized that the nature of the activity is far less important than the fact that the patient is doing something. An awareness of the regressive potential in illness has in many instances caused primary emphasis to be placed on keeping patients busy and active with considerably less concern for the nature of the action. We believe the nature or characteristics of the action experience are of primary importance. Involvement in an activity can be either therapeutic or damaging to the patient, and there-

fore it is essential that we become more aware of and more carefully evaluate the psychodynamics of activities.

For example, the overtly hostile, aggressive patient who fears and resents control and domination does become more hostile, anxious, and aggressive when he is expected to perform in a compulsive, passive, inhibiting, and/or therapist-controlled activity. On the other hand, the patient with repressed murderous rage, who fears his inability to control inner impulses, can be terrorized by the prospect of free, spontaneous action with few limitations and containing real or symbolic aggressive components. Extreme anxiety and depression can be precipitated and increased by expecting the depressed, insecure, dependent patient to participate in an activity requiring initiative, decisiveness, creativity, or overt or symbolic destruction.

Perhaps one of the most frequently discussed issues is concerned with the relative values of patient free-choice versus therapist-determined or prescribed activity. Whether a patient should have an activity chosen for him or should be given a free choice in selection is a therapeutic question and should always be answered on the basis of what seems to offer the best therapeutic potential for the patient at a given time. For some patients, decisions are impossible; there are those whose self-esteem is so poor that any decision they make may become identified with themselves and thus become inadequate, bad, or no good. Thus the decision itself, as well as results of the decision, is viewed in the same way. It has been our experience that initially making decisions for these patients relieves anxiety and improves their ability to utilize therapeutic opportunity. On the other hand, there are patients who cannot tolerate direction, who are threatened and made anxious by even the most covert or subtle

influence. Certainly these persons need to be allowed to make their own choice and decisions as they work through these fears.

Quite early in one's experience as an occupational therapist, it becomes fairly evident that many patients when allowed a free choice will select activities and objects that tend to reinforce their psychotic or neurotic defenses. This may readily be understood in the light of their defense mechanisms. Thus the free choice of a patient may need to be interrupted when the nature of his choice blocks efforts to reach him and to help him deal with his problems. An understanding of the psychodynamics of activities will enable the occupational therapist to help the patient select an activity that can more readily be expected to elicit feelings appropriate to the psychotherapeutic process. Such knowledge also makes it possible to guide the patient toward gratification of needs and/or toward a healthier, more constructive sublimation when this is indicated. A patient's interest in an activity or his choice should be viewed as a manifestation of his needs, his conflicts, and his manner of dealing with these. Decisions in terms of dealing with such manifestations and/or ways of eliciting response must always be made on the basis of the individual situation. When the primary purpose of the occupational therapy experience is to provide additional psychodynamic formulations about a patient, the free-choice method is certainly most effective.

In order to use activities and objects as psychotherapeutic tools, they must of necessity undergo a distinctive examination and evaluation. Dr. Azima,[1] in a paper titled "Dynamic Occupational Therapy," presents a dynamically oriented,

[1] Azima, H.: "Dynamic Occupational Therapy," *Dis. Nervous System,* Vol. 22, No. 4, 1961.

creative set of constructs concerning object relationships. This work focuses on the correlation of the symbolic meaning of objects with unconscious phenomena and outlines a procedure for evaluating and measuring responses to the objects. In another paper [2] Dr. and Mrs. Azima emphasize the significance of objects in occupational therapy and discuss their use in obtaining diagnostic and evaluative material, in detecting change in functioning, and in providing opportunity for gratification of basic needs and developing more adequate ego defenses.

Leonard Oseas,[3] in a study of the therapeutic potential of work, describes how the nature of certain work experiences may be used to achieve treatment goals and provide ego support and opportunities for reality testing.

Current literature and clinical experience seem to indicate a growing consensus that the use of activities and objects does have a psychodynamic impact on the performer. We believe that, as further study and research are devoted to this area, it will be possible to define and understand these dynamisms more clearly, and it is toward this awareness that we feel the profession must move.

The purpose of an activity analysis in this frame of reference is to help one arrive at some understanding of the basic and fundamental psychodynamic characteristics of a given activity. It is a guide to be used in evaluating one aspect of the activity experience. The use of activities as a psychotherapeutic measure requires a knowledge of the phenomenon of the unconscious, of the nature and meaning of symbols, and of individual psychodynamics, a sensitivity to

[2] Azima, H., and Azima, Fern: "Outline of a Dynamic Theory of Occupational Therapy," *Am. J. Occupat. Therapy*, Vol. 13, No. 5, 1959.

[3] Oseas, Leonard: "Therapeutic Potentials for Work," *Arch. Gen. Psychiat.*, Vol. 4, No. 6, 1961.

the probable impact of each of these on one another, and finally the ability to integrate such awareness into a therapeutic experience for a patient. The following outline, then, is offered for the purpose of assisting the student in arriving at some valid concepts concerning the basic characteristics of an activity. Such knowledge is the first step in better understanding the dynamics of occupational therapy.

OUTLINE FOR ACTIVITY ANALYSIS

1. *Motions*

a. Passive: Motions are considered passive when they do not involve active aggression, when the material or object moved against is pliable and nonresistive. Thus the motions in the use of clay are more passive than in stamping one's feet in a circle dance or punching holes in leather. Both the nature of the passivity and its frequency need to be evaluated.

b. Aggressive: Motions such as striking, beating, hammering, throwing, etc., in which force is required. Nature and frequency.

c. Destructive: An analysis of the nature and frequency of motions that lead to the destruction of the original object or material, such as sawing, tearing, cutting, carving, etc.

d. Rhythm: Is a rhythm of motion required or possible? To what extent are motions repeated? Varied? Multiple?

e. Size: What are the nature and extent of fine movement? Gross movement?

2. *Procedures*

a. Motor and mental coordination: To what extent does the activity require cognitive motor skills? What is the nature of this requirement?

b. What are the nature and extent of technical knowledge required?

c. Is manual dexterity required or possible?

d. Is there mechanical repetition of procedure? Are there few or multiple processes or steps? What is the extent of repetition of these?

e. What is the frequency of new learning required within the procedure?

f. Are there required delays or postponements in the process? Must or can completion be delayed and/or prolonged? To what extent?

3. *Material and Equipment*

a. Resistiveness: To what extent does the material or equipment resist the performer? What are the nature and extent of force necessary?

b. Pliability: Do the material and equipment offer little or no resistance? Do they support or assist the doer? Does the material take form readily? Is it easily influenced?

c. Controllability: Are the material and equipment readily controlled; i.e., do they contain enough substance and/or form to provide some of their own control? Are they so unstructured and pliable as to make control difficult? Does the material tend to resist change?

4. *Creativity and Originality*

a. What is the extent of opportunity to express feelings and ideas freely?

b. To what extent is performance or doing dependent on internal stimuli, creative thinking, planning, and implementation?

c. What is the nature or characteristics of opportunity for invention, alteration, original planning, and action?

d. What are the nature and extent of external limits and controls? To what extent does the nature of the equipment or material provide structure? To what extent does this structure inhibit or control creativity?

5. *Symbols*

a. What symbols are inherent in methods of procedure, material, equipment, end product?

b. What unconscious feelings, needs, drives may be represented by or symbolized in tools, equipment, motions, actions, etc.?

c. What is the potential for association?

6. *Hostility and Aggressiveness*

a. What are the nature and extent of hostile or aggressive expression directly and symbolically?

b. What characteristics of motions, actions, procedures, material, and equipment provide opportunity for hostile or aggressive expression directly? Symbolically? What are the potentials for sublimation?

7. *Destructiveness*

a. What are the nature and extent of actions or processes that destroy?

b. Is such destruction controlled? What are the nature and extent of this control?

c. What tools, equipment, actions, etc., may be considered symbolic of destruction? To what extent? What is the nature of this destruction?

8. *Control*

a. What opportunities exist for the performer to be in control of the situation? See paragraphs 2, 3, 4, and 9 of the outline.

b. To what extent is it possible for the performer to be in control of the learning experience? To what extent does participation require dependence on others for learning and/or performance?

c. Does the process, equipment, or material provide control and/or set limits?

d. What are the nature and extent of such limits and controls both symbolically and actually?

9. *Predictability*

a. To what extent can "results" and the nature of these be predicted? What is the frequency of new learning experiences? Of repetitive performance?

b. To what extent does the structure of equipment and material minimize chance of failure?

c. What is the possible extent of or necessity for guides, aids, rules, etc.? What is the nature of their "assistance" and "assurance"?

10. *Narcissism*

a. What opportunities exist for self-indulgence? Exhibitionism? Acquisition?

b. What are the nature and extent of creative opportunity? Omnipotent endeavor?

c. Is there an end product or demonstrable result? Does it have a monetary value?

11. *Sexual Identification*

a. What is the cultural frame of reference concerning the masculine or feminine connotation of the activity? Of the objects, actions, or motions used?

b. What are the nature and extent of aggressive resistive media and performance?

c. What are the nature and extent of passive, intricate, delicate media and performance?

d. What symbolic associations exist?

12. *Dependency*

a. What are the nature and extent of opportunities for being dependent on a person or existing structure (rules, patterns, etc.)?

b. What is the frequency of change and new learning experiences that require dependency?

c. To what extent are objects or processes symbolic of early infantile dependency? What are the characteristics of these?

13. *Infantilism*

a. What are the nature and extent of actual or symbolic oral activity, i.e., eating, sucking, blowing, etc.?

b. What are the nature and extent of anal activity, i.e., smearing, excretory substitutes, possessiveness, retentiveness, collecting, washing, etc.?

c. What are the nature and extent of opportunity for dependency? (See paragraph 12.)

14. *Reality Testing*

a. What are the nature and extent of sensory contact? Of well-defined structure?

b. To what extent is the process representational or reproductive rather than creative?

c. To what extent does the structure and/or process provide opportunity for agreement on the nature of reality?

d. Are there clearly established standards and techniques?

e. To what extent can purpose be perceived and results predicted?

15. *Self-identification*

a. What opportunities exist for the participant or doer to identify his contributions, efforts, and/or involvement?

b. What are the opportunities for unique, individual performance?

c. Is there an end product? To what extent can the end product or results provide personal identity?

d. What are the nature and extent of the opportunity to test the reality of one's perceptions?

e. What are the nature and extent of opportunity to deal with self-image and body distortions?

f. What considerations in paragraphs 4, 5, 8, 9, 10, 11, and 14 may influence the nature and extent of self-identification?

16. *Independence*

a. What are the opportunities for free and independent planning and performance? What is their nature?

b. To what extent may processes be altered to allow for uniqueness or creative endeavor?

c. What is the potential for successful competition?

d. To what extent is individual responsibility possible? What is the nature of such responsibility?

17. *Group Relatedness*

a. To what extent can performance and planning be shared with others?

b. Can processes be dependent on cooperation and mutual assistance from group members? What is the nature of this cooperation?

c. To what extent do the materials, tools, and equipment offer possible shared experiences?

d. To what extent can processes and the end product or results be adapted or varied to achieve social and/or cultural acceptability or commendation?

ADDITIONAL REFERENCES

ANDERSON, HAROLD H. (ed.): *Creativity and Its Cultivation.* New York: Harper & Bros., 1959.

GOLDMAN, ALFRED E.: "The Classification of Sign Phenomena," *Psychiatry,* Vol. 24, No. 4, 1961.

MILNER, MARION: *On Not Being Able to Paint.* New York: International Universities Press, Inc., 1957.

READ, HERBERT: "Art and the Development of Personality," *Brit. J. M. Psychol.,* Vol. 25, No. 2–3, 1952.

———: *Icon and Idea. The Function of Art in the Development of Human Consciousness.* London: Faber & Faber, 1955.

WHITTICK, ARNOLD: *Symbols, Signs and Their Meaning.* Norton, Mass.: Charles T. Branford, 1960.

CHAPTER 7

Utilization of Activities

It should be evident that the opportunity that exists for expression of attitudes, feelings, ideations, etc., at a nonverbal level can be of considerable value in the psychotherapeutic process and in understanding the unconscious of the patient. Those ideas, attitudes, and emotions that are acted out are much less likely to come under the scrutiny of one's more conscious intellectual repressing mechanisms. For this reason the action of the patient is quite likely to reveal more of the unconscious. Such experiences, in addition to being of communicative value, create for the patient an opportunity to find more expedient expressions and gratifications of basic needs.

The extent to which a patient is encouraged to talk about feelings associated with the activity process or object will depend on the skill and training of the therapist as well as the nature of the planned therapeutic approach. The degree of emphasis placed on the process of uncovering, supporting, or directing will indicate decisions in this respect, as well as the patient's readiness or ability to communicate certain as-

sociations verbally. The question of interpretation to the patient must also be answered on the basis of these considerations. When involvement in an activity is primarily for the purpose of diagnostic evaluation, interpretations are not made to the patient.

The purpose of this chapter is to attempt to translate some of the theoretic concepts of object relationships into more concrete practical application in order to integrate these concepts better. For this purpose, we will select some of the more important general problems in thinking and functioning of the psychiatric patient and discuss the nature and kind of object relationships and activity experiences that may impinge on these. We do this with a full awareness of the inherent dangers of oversimplification and overspecification.

Psychic phenomena contain a high degree of unpredictability and do not readily lend themselves to measurement. By the same token, manipulations of such phenomena cannot be spelled out in clear, unambiguous formulations or procedures. The material presented in this chapter, therefore, can have meaning and validity only to the extent that it is understood that these are examples of what can or might occur, that there are many variations of any given feeling or behavior, and that procedures for dealing with these cannot be precise or inflexibly specified.

It is also important to point out that difficulties in living cannot be isolated one from the other, that there is no clear-cut functional boundary separating, for example, the patient's self-concept, his sensory perceptions, and his narcissistic needs. Personality and pathology have many variables and complexities, and there are always varying combinations of these, although certain dynamisms may be perceived

as dominant at a given time. There is, however, a valid body of knowledge that enables one to make certain general predictions, and as one's knowledge and experience increase, it is hoped that ability to predict will increase.

SELF-CONCEPT AND IDENTITY

The nature of one's self-concept and personal identity is determined by one's early interpersonal relationships with the significant adult. To the extent that such relationships have been unsatisfying, anxiety-provoking, etc., one's self-concept and identity are distorted, confused, and/or inadequate.

Building and reconstructing a more healthy ego is the purpose of all psychotherapeutic endeavor. Thus all formulations presented here are, hopefully, directed ultimately toward helping the patient develop a more complete and realistic concept of himself as a person distinct from others, understand the nature and potential of this person, and increase his capacities to realize his potential. It is readily understandable that working through problems in interpersonal relationships, hostility, dependency, etc., will create a growing awareness of the self and a personal identity and integrity. Such growth experiences, however, may be expanded and further solidified through the use of activities or objects that provide opportunity for increased use and exploration of the senses; thus experiences are provided that can increase the realistic growing awareness of one's inner self (ego) as well as of body concepts.

For the patient with very limited ego structure, experiences in handling and manipulating clearly defined and structured objects can be extremely helpful. Experimentation

with and exploration of his perceptions and how he acts on these perceptions enable the patient to begin to perceive more accurately and better understand "what I am," "how I function," and the limits and capacities inherent in "me." Moving the body in a dance or circle game in response to sound, rhythm, or feeling; communicating with another person, experiencing physical contact, touching and identifying parts of one's own body; acting out feelings in a play; tracing a body or a head; reproducing a still life from one's perceptions; creating from a lump of clay or an assortment of paints—these are only a few examples of such meaningful experiences.

Self-image and body distortions frequently can be expressed and worked through in the process of making self-portraits in paint or clay and/or in the creation and use of symbolic self-representations.

Mr. D., a 45-year-old man, was admitted to the hospital because of increasing depression, withdrawal, and preoccupation with ideas of worthlessness to the extent that he became unable to work or leave the house. His acute illness was precipitated by a change in his position from sales manager to assistant in the firm where he had been most successfully employed for many years. The change occurred as a result of the merger of two companies and was not considered by his employer to be based on his ability. However, Mr. D. saw this as failure and as an indication of his inadequacy. From the point of view of his employers and acquaintances, this man was a successful and competent executive, a good businessman with considerable success in his position as well as in the stock market. In addition, he had been able to function successfully as one of the major community leaders. The patient, however, had always seri-

ously questioned his own abilities and looked on most of his efforts as failures and on himself as incompetent and inadequate. Physically, the patient was an extremely large man, tall, and very obese. He made frequent references to his size in a joking, derogatory manner.

It became evident fairly early in treatment that this man felt he was judged and accepted only on the basis of what he could do and how much he could produce. Thus it was essential to guard against having his experiences in occupational therapy become involved in his need to do and accomplish specific tasks or projects but to focus on opportunities to explore with the patient his concepts of himself, his feelings about being loved and accepted, and his means of obtaining such gratifications.

As this patient worked with clay, he began to make "an obese elephant" with extremely thin legs and no trunk. A large, disproportionate trunk was added later. The thin legs and long, large trunk caused the piece to fall and the trunk to break each time the patient attempted to place it in an upright position. He made repeated angry, forceful, and unsuccessful efforts to stand the elephant on his feet but did not attempt to change the leg or trunk structure. At this point he walked out of the room, remarking, "It's no damn good, can't even stand up."

This experience was used with the patient to explore his concepts of himself as an inadequate, castrated male and his ambivalence about needing or accepting help with its implications of change. Subsequent occupational therapy sessions were used to elicit, through objects, expressions of unconscious material and to help the patient begin to associate with these. In psychotherapy this material was more intensively explored and worked through.

Further growth of a self-concept may be reinforced by activities or situations that emphasize personal identity, such as having personalized projects, making things for the patient's own possession, or having his own working or storage area. Ego maturation can be given further impetus through the narcissistic gratifications found in self-care, in opportunities for and encouragement of personal grooming and the making of one's own clothes or costume jewelry, and in the use of activities that assure a successful endeavor for the patient within his current capacity. A sense of personal worth and the development of his own standard of values can be enhanced ultimately by activity situations in which the patient can make successful decisions, see his ideas materialize, and eventually successfully compete with others.

SEXUAL IDENTIFICATION

Confusion about, distortion of, or lack of sexual identification is, of course, part of the patient's difficulties in self-concept and lack of ego maturation. Necessarily, those objects providing experiences that can be used toward the growth of a realistic concept will also assist the patient toward appropriate sexual identification. Certain activities and objects within a given culture and society have a masculine or feminine association. Usually those activities or processes that require primarily aggressive, resistive action are identified with the masculine role, whereas the more passive, creative, or intricate ones are more frequently associated with the feminine role. The end product also in many instances may have a connotation associated more or less with the masculine or feminine role. The need of the patient for such identification and his relative degree of comfort in crossing

these boundaries will influence the use of such activities, as well as provide information about the nature and extent of his identification. For example, one male patient who had great difficulty differentiating masculine and feminine roles seemed to obtain reassurance and help from observing the female occupational therapist's involvement in sewing and knitting, and he became very anxious and confused on one occasion when she began to use a saw.

In the occupational therapy setting the patient has many opportunities to observe the role identification of others as exemplified in object choice and process. Opportunities to identify with the therapist or another person and a particular group can be useful, as can the opportunity to observe that such boundaries can be crossed without loss of identity.

INFANTILE ORAL AND ANAL NEEDS

The development of a realistic self-concept and ego strength can occur only to the extent that one's primitive narcissistic needs are gratified. Occupational therapy can offer opportunities for the expression and gratification of these needs through activities that involve sucking, drinking, eating, chewing, and blowing and those that use excretory substitutes such as smearing or building with clay, paints, or soil. However, the successful use of any of these activities for these purposes is determined by the appropriate selection of an object or activity for a given patient and his ability to become actively involved in such regressive behavior. It is essential that the therapist support the patient in his regression as his needs indicate. As the patient is able to experience gratification of some of his infantile

oral and anal needs, other activities can assist him in developing healthy sublimations for some of these needs. Thus the objects and activities may gradually be less symbolic of the original need, and the eating, sucking, or blowing may be replaced by activities that involve preparation of food first for himself and then for others, or caring for and feeding animals, or blowing musical instruments; whereas the anal activities may progress toward possessive retentive ones, such as collecting, filing, bookkeeping, gardening, and doing laundry.

Karen, an 18-year-old girl, had been hospitalized for five years. She was a mute, autistic girl who spent most of her time sitting on the floor in the corner of the dayroom picking at her skin and twisting her hair. She was inaccessible to interview psychotherapy, and medication did not appreciably change her behavior.

The occupational therapist then began to make contact with this girl through food. Over a period of several weeks she was given candy, chewing gum, soda, and milk. As she began to respond to this feeding, Karen was able to leave the ward with the occupational therapist and help to cook simple food for them to eat together. Ultimately the patient was able to talk during these experiences and later began to speak to her doctor when he would give her food and also in the dining room while she was eating. As the eating and cooking experiences continued in occupational therapy, Karen began to assume more responsibility for both the planning and the cooking and was able to reach out to patients and staff by making candy and cookies for the ward. She was able to work with her psychotherapist and assisted in the hospital diet kitchen until her discharge.

DEPENDENCY

Many patients have a basic dependency need to be infantilized. This need is coupled with fear of such relationships and constant expectation of rejection and/or loss of the love object and the ambivalence that such a dichotomy creates.

Some patients can fairly readily enter into a dependent, clinging relationship and activities involving soft, nonresistive material and nonaggressive performance, and activities particularly associated with oral and anal needs can be used to further develop and explore this relationship as well as provide gratification.

For those patients whose fear of such relationships prevents gratification of these needs, objects symbolic of these needs, and the manner in which the objects are presented and used, can support the patient in working through some of these fears and in developing such a relationship.

Initial interpersonal contacts that focus on guidance and assistance in an activity or in the use of an object rather than on the direct person-to-person situation are less threatening and make contact with others more tolerable for the patient with such fears. In occupational therapy, guidance and assistance are normal in the course of events. Help in setting up the projects and guidance in this development provide excellent means for meeting some of the patient's dependency needs. In addition, these needs can be further gratified by activities that are learned by imitation with a minimum of verbalization and a maximum of working together, or by those having a sequence of clearly defined steps

that can be taught unit by unit, thereby providing short but continuing contact. As the patient becomes able to tolerate a closer, more dependent relationship, the nature of the involvement and the kind of object will change to provide support and gratification in a more dependent relationship.

Mrs. T. S., a 32-year-old woman, had been admitted to the hospital because of increased anger, which she could no longer control, hyperactivity, and suspiciousness. She had become completely overwhelmed by the demands of her two small children and was no longer able to care for them. Psychiatric interviews indicated that this patient had very strong dependency needs which were anxiety-provoking for her and which she denied to the extent that she was unable to form any really close relationship and ultimately became unable to give, even to her children. She was an aloof, critical, controlling, and hostile woman.

In occupational therapy it was suggested that she make a piece of jewelry for herself. Since the occupational therapist was unfamiliar with the particular craft process, it was arranged for them to work together from a book of instructions. Mrs. S. would read the directions aloud to the therapist, and they worked in this manner until the project was completed.

Emphasis on the activity and learning process made it possible for this patient to work with another person with much less feeling of threat, and the use of the book of instructions provided a sense of both safe distance and control, which was necessary at this time. The success of their shared experience made it possible for the patient to feel more secure in this relationship and to begin to accept a more dependent relationship.

HOSTILITY

Projected and introjected hostility are extremely frightening since such feelings are perceived as ultimately destroying oneself and others. This is particularly true for the schizophrenic, whose perceptual vagueness creates a sense of limitlessness, making destruction almost limitless, so that even minimal or incidental hostility is dangerous. Although it is indicated that dealing with some of the needs and problems relative to interpersonal distortions and other basic needs will result in a diminution of hostile feelings, it would seem that still other therapeutic measures can give the patient additional help in dealing with these feelings.

Usually patients are able to express hostile, aggressive impulses with less anxiety toward a symbolic object or through a symbolic act than toward a person. When fear of hostile impulses is so great that hostility or resentment is almost completely repressed and when help is needed in expression and awareness, objects and/or actions symbolic of such feelings can be used with relative comfort to the patient. Thus, taking the part of an angry character in a play, participating in a relatively aggressive circle dance, or using oral and anal aggressive performance, such as chewing, singing, blowing, or smearing, can be of particular benefit.

When hostility is overtly manifested, the way in which this is to be handled will determine the kinds of objects offered and the nature of the processes encouraged. Opportunities to perform or "act out" hostile, aggressive feelings and impulses will give the patient a chance to become aware of and explore further these feelings and their motivations. If therapy is being directed more toward repression and

control, the activities may help him find healthy, acceptable sublimations. Such activities are those involving sewing, cutting, hammering, etc., with resistive media.

For some patients, although they may overtly express their anger and hostility, considerable anxiety exists relative to fear of completely losing control. Such anxiety may become profuse, calling forth more hostile expression which, in turn, increases the anxiety and seriously interferes with the patient's functioning as well as with the therapeutic efforts. In these instances, objects and, more particularly, those activity processes that provide clearly defined limits and control in constructive hostile aggressive action can interrupt this process and allay the patient's anxiety.

The nature of occupational therapy also makes it possible to structure these situations so that limits can be set for the nature and extent of such expression in accordance with the patient's tolerance and need. Such supportive limits may be established by the nature of the activity or object, i.e., hammering within a mold, batting a ball, sewing, or cutting to a line. Further impact is given this experience when such hostile, aggressive performance ultimately results in a project that is meaningful to the patient or gains for him approval from others with whom he has participated. Such occurrences give him the experience of engaging in aggressive action that is ultimately constructive rather than destructive. These statements in no way indicate that destruction should always be diverted, since in some instances the nature of the patient's object relationships makes it necessary for him to destroy the object. It is essential, however, that the patient be aware that there exist elements of control, external to himself, that will prevent his destruction from getting out of hand; frequently, in addition to the

therapist's support, certain aspects of the activity situation can be used advantageously in this respect. For example, one patient was considerably relieved when the hammer he was using to vigorously pound metal into a mold was tied securely to the end of the workbench. Another was visibly relieved and began to talk about his hostile destructive impulses only after he was removed from metal hammering and given a large four-harness loom to "beat," which was securely tied to the radiator, and after he had reassured himself about the impossibility of the beater's coming off in the process.

REALITY TESTING

Perceptual vagueness makes it difficult to be sure of what is real and what is not real, and such difficulties may be manifested in distortions about oneself and the external world and by confusion, impaired judgment, indecision, and even disorganization. The need for "consensual validation" or a shared reality is critical.

The "realities" of objects and activity processes, their delineation of form, and clearly defined procedures provide tangible support to the patient in dealing with some of his perceptual difficulties. Gross muscle movement and rhythmic activities give one the experience of relating oneself, one's body, and the senses to space, movement, and objects, helping develop more accurate, realistic perceptions. The structured activities in occupational therapy provide opportunity for reality testing since they offer sensory contact in a composition that is well defined and not easily altered or distorted and contain clearly delineated procedures involving representational or reproductive techniques. Many ac-

tivities in occupational therapy provide opportunity for an agreement on the nature of reality because they have easily understood and accepted values and purposes, have established standards and techniques, and may require varying degrees of intercommunication. In addition, a "shared reality" is frequently achieved by the patient's active participation with others in a reality-centered activity or as a participant-observer of the common realities and unrealities within the total situation. A patient hospital newspaper group met twice a week to review material submitted for publication. In the process of discussing and evaluating such material, they began to exchange ideas about what is fact and what is fantasy, what are "sick ideas," how others' perceptions are like and unlike theirs, etc. These meetings provided excellent opportunities for the patients to explore their real and fantasy worlds and come to some consensus about these. It is necessary to point out that, although the patient needs to experience a shared reality, he also needs at times to express or act out his fantasies, and the two needs are not mutually exclusive. The process of creating an object or selecting an activity can be the means whereby the patient can express his fantasies as well as his unacceptable feelings, attitudes, and impulses.

COMMUNICATION

When verbal interaction or expression is difficult or impossible for the patient, creative and structured activities in occupational therapy provide opportunities to communicate problems and feelings. Such nonverbal communication may also be controlled by the selection for the patient of a specific activity that can be expected to elicit responses to a

given problem or conflict. Considerable study has been done in the use of creative arts in uncovering the unconscious and in helping the patient develop an awareness of some of his problems. Far less attention has been given the use of the more structured activities for this purpose, and yet these also offer numerous opportunities for communication and expression. How the patient handles and uses a specific object, the significance of his choice of an activity or project, and the nature of his action are often clear indexes to his drives, defenses, and interpersonal problems and are only a few of the possibilities for communication of these. In addition, active participation is an experience in which the patient can almost see his feelings at work and can perhaps, therefore, find it a little easier to look at them. Although communication implies some degree of interaction between two or more persons, the nature of the group formation in occupational therapy makes it possible for social interaction to be controlled. Since the techniques of both individual and group activities are utilized, social relatedness can be graded for the patient in keeping with both his need and his tolerance.

It is evident that one's sense of security is in proportion to one's ego strength and development. Thus, feelings of insecurity occur when there are failures and difficulties in the process of growth and development. Faulty or unsatisfying interpersonal relationships with the primary love object or significant person in one's early life experience result in the thwarting of basic ego needs—to be loved and accepted —creating distortions and faulty concepts of oneself and others. Such distortions then seriously interfere with one's attempts to communicate and obtain gratification and result in feelings of insecurity. As such, then, insecurity may

be considered basic to emotional difficulties. It then becomes necessary to develop certain methods of defense against the anxieties inherent in feelings of insecurity. Insecurity and concomitant anxiety are then manifested in a tenacious hold on defenses and in the difficulties and inabilities of the patient to venture forth in exploring relationships and experimenting with means of more satisfactory gratifications.

To more clearly understand what one is doing in therapy, it becomes important that a distinction be made between the patient's manifested needs that may be essentially ego defenses and those needs and problems that are considered basic to his problem or ego integration. Certainly basic and fundamental changes in the way a patient perceives himself and others and acts on these perceptions result from changes and alterations in his basic pathology, and this is the primary concern of the psychotherapeutic process. Frequently, however, the ego defenses (defense mechanisms) get in the way of such an endeavor and must be worked through before one can deal with the more basic needs of the patient. For example, it may be necessary to meet the patient's manifested need for control, obsessive-compulsive performance, competition, self-depreciation, or manipulation in order to re-establish his "sense of security" and free psychic energy, which then can be used to deal with more basic issues. Or this problem may be manifested by seemingly conflicting needs; i.e., the patient may indicate that he wants to be punished but actually needs to be supported and reassured, or he may behave in an independent, removed manner while actually needing to be dependent in an almost infantile way.

The extent to which one should deal with primary or secondary needs will vary with each individual situation and be determined by the uniqueness of individual problems

and the extent to which uncovering, supportive, or directive approaches are to be used.

The use of objects and the processes inherent in the use of such objects do not occur in a vacuum. The patterns of interaction, identification, and shared experiences that surround such involvement, either spontaneously or by design, create a gestalt of experiences. Those experiences in occupational therapy that focus more on participative doing than on things, e.g., play-reading groups, drama, dance, music, newspaper work, provide opportunities for the patient to test his new skills in living, experiment and explore capacities in relationships, learn more effective means of communication, and utilize insights gained. These, then, provide an additional dimension to the psychotherapeutic process. Finally, occupational therapy encompasses thinking, feeling, and participation in a world of objects. Such a setting bears a closer resemblance to actual living situations than any other treatment setting, thus providing a realistic environment in which the patient, when he is ready, can test his developing skills in living. Likewise, the transition from treatment to the normal living situation is minimal.

REFERENCES

BRODY, E. B., and REDLICH, F. C. (ed.): *Psychotherapy with Schizophrenics*. New York: International Universities Press, Inc., 1956.

PRATT, DALLAS: "Making the Environment Respond to Emotional Needs," *Psychiatry*, Vol. 15, No. 3, 1952.

RUESCH, JURGEN: *Therapeutic Communication*. New York: Robert Brunner & Co., 1962.

SEARLES, HAROLD F.: *The Nonhuman Environment*. New York: International Universities Press, Inc., 1960.

SIGNORI, E. T.: *Interpretive Psychology: The Nature of Human Activity*. Toronto: McGraw-Hill of Canada, 1957.

CHAPTER 8

Occupational Therapy as a Diagnostic and Evaluative Process

As theoretic formulations and functions concerning occupational therapy are explored, it becomes increasingly evident that the occupational therapy experience provides many opportunities for gaining information that will contribute to psychodynamic formulations about a patient. When occupational therapy is used to gain information that contributes to diagnosis and treatment planning, it becomes a medical procedure and is involved in the management of the medical entity being treated. Diagnosis in psychiatric work, just as in any other, requires eliciting of responses to known stimuli. The efficacy, then, of observations and evaluations is in proportion to one's knowledge concerning the given stimuli, skill in eliciting and understanding a response, and professional information of a scientific nature sufficient to ensure selection of those observations that are most significant for the accumulation of diagnostic data.

Realization of the potential of occupational therapy in this area as in other areas, then, is dependent on the extent of knowledge and training in dynamic psychiatry and in the psychodynamics of activities. Training of the occupational therapist in this area has lagged far behind the needs of the field and behind allied professions. There are indications of increasing attempts to explore the meaning and use of activities, and as we develop an ability to assess more scientifically what we do and its rationale, we increase capacities for measuring the nature and quality of our processes.

The use of occupational therapy to provide data that will contribute to psychodynamic formulations has been explored remarkably well in *Changing Concepts and Practices in Psychiatric Occupational Therapy.*[1] This work, representing a rather extensive survey and study, indicates many of the problems inherent in this area and attempts to arrive at some explanation for these problems. Some of the more common reasons given for difficulties in using occupational therapy as an evaluative measure are listed as (1) the occupational therapist lacks training and knowledge and can therefore rely only on intuitive judgment; (2) the psychiatrist and other clinical staff do not use the information when it is given; (3) the psychiatrist and others have little opportunity or incentive to learn what occupational therapy can offer and, therefore, do not ask for material; (4) information gets lost or diluted in the "progress notes"; (5) the occupational therapist feels his information is neither pertinent nor valid and, therefore, does not voice an opinion.

The burden that this evaluation places on the occupational therapist is obvious. The same study also summarizes the

[1] West, Wilma (ed.): *Changing Concepts and Practices in Psychiatric Occupational Therapy.* Am. Occupational Therapy Association, 1959.

educational and training needs of the profession relative to its function as a diagnostic tool, indicating the need for improved educational experiences in the following areas: (1) knowledge of individual psychodynamics, (2) knowledge of group dynamics, (3) knowledge of the psychodynamics of activities, (4) experience and training in observational techniques, (5) experience and training in translating what is observed into useful evaluations, and (6) assumption of responsibility for communication with other staff members.

We will attempt to define significant experiences occurring within occupational therapy and point to some ways of using them to obtain information about the patient. Such attempts are made within that frame of reference which recognizes that many factors are of possible significance in psychiatry and that different psychiatrists and schools of psychiatry place emphasis on different factors. The ability to discern the kind of information that will be most useful in a given setting can come only with increasing breadth of knowledge and practical experience in relation to various psychiatrists and situations. A text of this nature can at best attempt to provide some guidelines for investigation and study and thus hope to produce motivation toward increased learning for the occupational therapist.

The interactions of the patient with the therapist, with the group, and with the activity are experiences within occupational therapy that provide a rich source of information. Many advantages accrue from the fact that occupational therapy is an action-oriented rather than primarily verbal therapy. As we have indicated, those attitudes, ideas, and emotions that are acted out are much less likely to come under the scrutiny of one's more conscious intellectual repressing mechanisms. For this reason the activity and inter-

action of the patient are quite likely to reveal more of the unconscious thought, emotions, and attitudes. A number of studies have been made concerning the use of occupational therapy as a "projective technique," the most notable and thorough of these being the work done by the Azimas [2] at Alan Memorial Hospital and the studies at Mt. Sinai.[3]

The stimuli to which the patient's reaction can be evaluated consist of objects both real and symbolic, the process of using these, the product, the use of the product, the relation to authority, and usually the relation to peers. To evaluate this material requires skill in observation derived from training and experience.

It should be pointed out that when we speak of the evaluative and diagnostic potential in occupational therapy, we do not limit this to the initial evaluation for treatment planning or for verification of diagnosis. It must be remembered that diagnosis and treatment are not static affairs and that both run concurrently and both may reveal changes from time to time. The nature of occupational therapy experiences makes it possible frequently to predict changes in patient behavior and to measure the nature and quality of changes in psychologic structure. Azima [4] emphasizes the usefulness of occupational therapy in recognizing and evaluating change in the psychic process. The use of occupational therapy as a process for measuring and predicting change and for evaluating psychotherapeutic progress has been neglected. Such lack of development reflects the need

[2] Azima, H., and Azima, Fern: "Outline of a Dynamic Theory of Occupational Therapy," *Am. J. Occupat. Therapy,* Vol. 8, No. 5, 1956.

[3] Linn, Louis; Weinroth, Leonard A.; and Shamah, Ruth: *Occupational Therapy in Dynamic Psychiatry.* Washington, D.C.: American Psychiatric Association, 1962.

[4] Azima, H.: "Dynamic Occupational Therapy," *Dis. Nervous System,* Monograph Supplement, Vol. 22, No. 4, 1961.

for increased knowledge and concomitant skills in this area and for increased research and study. It would also seem to indicate that further energies be directed toward improving communication between the occupational therapist and other staff members. It is necessary not only to perfect one's skills and knowledge but to assume responsibility for sharing these with others. The more frequent and dynamic the communications, the greater will be the validation of observations and the usefulness of those made.

On the basis of the nature of occupational therapy, we have delineated five general areas in which the occupational therapist should be able to provide information that will contribute to patient evaluation.

1. *Concept of Self:* To assess how the patient perceives himself and how he functions within this concept. The nature of his body image, identification, self-esteem, etc.

2. *Concept of Others:* How he perceives others and how he may be expected to relate to others. What expectations he has concerning relationships; how he views authority and peers; what interpersonal distortions exist; and how he behaves in relation to these.

3. *Ego Organization:* The nature and extent of his capacity for reality testing, the validity of his perceptions, the nature and degree of his capacity to organize, control, predict, follow through, etc. The extent of his recognition of the real-unreal, of the me–not me, and the quality of his defenses.

4. *Unconscious Conflicts:* A delineation of areas of unconscious conflict, of frustrated basic needs and drives, of conflicting impulses and needs and areas of functioning that generate anxiety, elicit defenses, etc.

5. *Communication:* The nature and manner of communicating feelings and thoughts. The nature and extent of verbal

and nonverbal communication, his use of symbols, effectiveness of communication, areas of difficulty, etc.

The following outline, then, is provided as a guide in obtaining information and recording observations.

OUTLINE FOR EVALUATION

1. *Relationship to the Therapist*

a. What is the nature of the patient's overt behavior toward the therapist? (See Behavioral Characteristics, p. 107.) How is this manifested?

b. What situations or experiences within the patient-therapist relationship increase or diminish such behavior?

c. Does the patient succeed in communicating feelings and ideas? Is communication difficult to understand, incomprehensible, expressed in a bizarre or other abstruse manner? Describe.

d. Is the patient's communication primarily verbal or nonverbal? Are actions (behavior) and verbal expressions coordinated, or is there a difference in how he behaves and what he says? What is the nature of this disparity?

e. What defenses does the patient use in the relationship? (See Defense Mechanisms, p. 107.) How and under what circumstances are these defenses used?

f. What unconscious conflicts concerning the relationship seem to exist—conflicting needs, drives, impulses, etc.? What is the nature of these and how are they indicated?

g. What fears are manifested concerning the relationship? Under what circumstances does the patient seem to be most threatened? Most comfortable? To what extent and in what manner?

h. How do you as a person seem to corroborate or refute some of his stereotyped role concepts? How is this responded to or handled by the patient? What does he seem to expect of you?

i. How does the patient conceptualize himself in the relationship? What is the level of his self-esteem, feelings of adequacy, identification, etc.? How are these attitudes communicated to you?

j. What is the patient's level of awareness of feelings, interaction, conflicts? What is the nature of his communication concerning this?

2. *Relationship to the Group*

a. What overt behavioral characteristics are evident in the patient's relationship to the group? (See Behavioral Characteristics, p. 107.)

b. Is behavior in relation to the group fairly consistent or is there a marked difference in behavior toward certain group members? What is the nature of this difference?

c. How do group members behave toward the patient? Describe the nature and quality of this behavior.

d. What feelings does the patient elicit from the group? In what way and how is this handled by the group? By the patient?

e. What fears and unconscious conflicts does the group seem to elicit in the patient? How does the patient express such conflicts and how does he handle them?

f. What ego defenses does he use in the group? How and in what circumstances? How does the group respond? What is the extent of his control of feelings and impulses? What is the nature of this?

g. What are the nature and level of the patient's communication within the group? (See paragraphs 1c and 1d.)

h. What is the patient's role in the group?

i. How does the patient see himself in relation to the group? To individual members of the group? How is this manifested?

j. How does the patient feel about the group? About individual members? How are these feelings expressed?

k. What is his level of awareness of the group process, of feeling about the group, of the group's attitude toward him, of his interpersonal distortions, etc.? To what extent is he able to integrate such awareness?

3. *Relationship to the Activity*

a. What are the characteristics of the activity the patient selects? What factors outside these characteristics seem to influence his choice —i.e., to please or comply with the therapist, to gain the group's approval, to defy, etc.?

b. How does the patient respond to and deal with the realistic and/or symbolic characteristic of the activity? (See Activity Analysis, pp. 76–80.)

c. What feelings are expressed in the content and in the way he handles the *material*, the *process*? Such as:

(1) Use of form, movement, space.
(2) Range and intensity of color.
(3) Nature and use of symbols.
(4) Quality of realism, distortions, fantasy.
(5) Nature of his handling (stroking, rubbing, messing, tearing, beating, pushing, etc.).
(6) Body response (muscle tension, facial expression, rigidity, etc.).
(7) Content of form (animate, inanimate, human, animal, whole or part, etc.).
(8) Nature of procedure (organized, meticulous, perfectionistic, decisive, persistent, sloppy, inaccurate, perseverating, etc.).

d. What needs and drives are expressed in his handling of *material*, of *process*, and in *content*? (See paragraphs 3b and 3c.) What is their nature?

e. To what extent does the patient seem to be aware of feeling? What is the nature of this awareness and how does he use it?

f. What ego defenses are manifested in the handling of material and objects? In the content? In what ways are these manifested?

g. What are the nature and quality of the patient's body image as it is manifested through performance and content?

h. What is the nature of the patient's self-identity? His concept of self, self-esteem, adequacy, sexual identification, worthlessness, etc.? How is this manifested through the use of the material, objects, content, and the process?

i. How does the patient handle abstraction, conceptualizations, concreteness?

j. What is the patient's level of organization, comprehension, perception, ability to predict as evidenced in performance and content?

k. Does the patient handle material and objects in a realistic or symbolic way? Is content realistic, symbolic, fantasy? In what way?

l. Are performance and content comprehensible? Can others understand what he is communicating? Is it idiosymbolic, bizarre, uncommunicative, or can it be consensually validated?

m. To what extent is the patient able to perceive his assets and limitations? How does he act on this? To what extent is he aware of what he can and cannot do?

n. What are the nature and extent of control? How is the control manifested?

o. What are the nature and quality of investment in the end product? Is it made for a purpose? For whom? Completed, destroyed, unfinished? Does he compare it with that of others?

Some terms that may be used to describe behavioral characteristics:

aggressive	efficient	masochistic
ambivalent	exhibitionistic	meticulous
anxious	fearful	narcissistic
autistic	hostile	negativistic
competitive	hyperactive	passive
compliant	indecisive	possessive
compulsive	independent	realistic
confused	infantile	rigid
controlling	ingratiating	sadistic
critical	inhibited	seductive
dependent	insecure	suspicious
detached	intellectual	unrealistic
diffuse	manipulative	withdrawn

Some terms that may be used to describe ego defenses:

avoidance	projection
compliance	reaction formation
denial	regression
detachment	repression
displacement	ritualization
intellectualization	sublimation
introjection	withdrawal

Some discussion concerning the matter of interpreting patient behavior seems indicated at this point since this frequently becomes an issue when evaluations are discussed. Any attempt to understand or evaluate behavior requires that one make some sort of interpretation concerning such

behavior. Acceptance of the phenomenon of the unconscious commits us to the acceptance of the fact that action and words are frequently used to mask feelings. Attempts to understand and recognize these feelings are concerned with interpreting or translating actions and verbalizations. The extent of one's accuracy is of course related to one's knowledge, experience, and collaboration with others, including the patient. Inherent in the designation of "professional" is the expectation that a body of knowledge exists sufficient to enable such a person to make useful interpretations. Interpretations should always be made with the understanding that they have meaning as impressions of one individual and, as such, are to be tested through the process of consensual validation.

It would seem evident that impressions or interpretations of a patient's behavior by a staff member involved with this patient are essential to an understanding of the interaction between these two, as well as an understanding of the patient's way of thinking, feeling, and behaving. It must be recognized that we constantly make interpretations in all interpersonal contacts. We react to people on the basis of the judgments (interpretations) we make concerning the meaning of their behavior toward us. Most frequently such interpretations are communicated at a nonverbal level through action. For example, we may interpret the turning away of an acquaintance from us as anger toward us or rejection of us and react toward that person accordingly. Mothers constantly interpret the cries and actions of their children and react on the basis of their assumptions. Our feelings for and behavior toward others are appreciably influenced by what we perceive (interpret) as their feelings toward us. The more opportunity that exists within a rela-

tionship for exploring and validating these impressions, the sounder the relationship and the more valid the interpretations. Although we may be somewhat more guarded in our behavior toward patients, both the patient and we ourselves are constantly interpreting one another's behavior and responding on the basis of such interpretations. Both parties are always more or less aware of this process. How we perceive another's behavior is colored by our expectations and our characteristic way of viewing ourselves and others. Thus we may interpret the turning away from us as anger if we characteristically see others as angry and hostile, or we may perceive this as rejection if we characteristically see ourselves as unacceptable and unworthy. The reality or validity of our judgments or perceptions is in proportion to our self-awareness and our distortions concerning ourselves and others. Increased capacity to make interpretations that will be useful, then, is dependent on improving one's knowledge of self and of dynamic psychiatry as well as on increasing the opportunities for corroboration with others that will then lead to consensual validation.

The extent to which one's impressions and/or interpretations should be made directly on a verbal level to a patient will depend on the psychotherapeutic plan, the extent of the patient's capacity to accept the interpretation and use it constructively, the opportunity that exists for consensual validation with staff and with the patient, and the skill and knowledge of the therapist. Certainly when the occupational therapy experience is being used entirely as a diagnostic or evaluative procedure, interpretations to the patient are not made.

In those institutions where patient programs are carried out by aides and assistants, the following charts and defini-

[*Text continued on p. 112.*]

PATIENT PROGRESS REPORT

Scale: 0—None
1—Minimum
2—Moderate
3—Extensive

ATTITUDE TOWARD GROUP AND STAFF	JAN.	FEB.	MAR.	APR.	MAY	JUN.	JUL.	AUG.	SEP.	OCT.	NOV.	DEC.
1. Expansive												
2. Hostile												
3. Aggressive												
4. Resistive												
5. Negativistic												
6. Dependent												
7. Sociable												
8. Leading (group)												
9. Following (group)												
10. Reticent												
11. Cooperative												
12. Responsible												
13. Accessible												
14. Dependable												
15. Competitive												

ACTIVITY ACCOMPLISHMENT
1. Comprehension of directions
2. Execution of directions
3. Retention of directions
4. Industry
5. Initiative
6. Productivity
7. Personal neatness
8. Activity neatness
9. Interest in activity
10. Interest in accomplishment
11. Coordination
12. Concentration
13. Performance standard
14. Skill
15. Decisiveness

Patient

O.T. assistant

tions may provide some guidelines to recording patient attitudes and behavior.

PROGRESS SHEET INTERPRETATIONAL KEY

Attitude toward Group and Staff

1. Expansiveness: Is the patient accelerated in thought and behavior? Does he attempt to do many things at one time? Is it difficult to sustain interest because of accelerated thought and hypersensitivity to environment or hyperactivity?

2. Hostility: Does the patient show an unfriendly attitude? Does he in action or speech reflect animosity or enmity?

3. Aggression: Is the patient self-assertive, pushing, enterprising? Does he act out animosity and hostility?

4. Resistance: Does the patient repel or oppose directions, suggestions, etc.? Does the patient refuse to follow directions within his emotional and mental capabilities?

5. Negativism: Does the patient do the opposite from what he is told? Does he ask for instruction and then proceed in an opposite manner?

6. Dependency: Does the patient rely on the therapist for decisions and directions? Does the patient lean on the therapist for emotional support and guidance?

7. Sociability: Does the patient contact and work with other patients? Does the patient participate in group activities? Is he friendly, affable, accessible to others in the group?

8. Tendency to lead the group: Does the patient take the lead in group activities? Does he attempt to organize the group or get other patients to participate?

9. Preference to follow: Does the patient actively participate in group activities without being a leader? Does he follow and conform to group organization?

10. Reticence: Is the patient inaccessible, withdrawn, shy, insecure? Does he require coaxing and encouragement before participating in group or individual activities?

11. Cooperation: Does the patient comply with general rules of procedure and performance? Does he refrain from making demands on the therapist and others?

12. Responsibility: Is the patient able to accept responsibility for his own behavior and activity in the group? Is he able to accept and meet obligations?

13. Accessibility: Is the patient approachable, responsive? Is the patient open to influence and reason?

14. Dependability: Is the patient trustworthy, reliable? Can he usually be depended on to perform in an acceptable manner?

15. Competition: Does the patient show in conversation or behavior a desire to equal or excel? Does he compete with other patients for the attention of the group or individuals? Does he attempt to excel in activities and/or performance?

Activity Accomplishment

1. Comprehension of directions: Does the patient readily understand verbal directions? Does he grasp the meaning of instructions?

2. Execution of directions: Is the patient able to follow directions once they have been given him? Is he able to proceed according to issued instructions without undue assistance and explanations?

3. Retention of directions: Is the patient able to remember directions once they have been given?

4. Industry: Is the patient energetic? Is he a diligent, purposeful participant?

5. Initiative: Is the patient self-starting? Is he self-reliant, enterprising? Does he originate constructive ideas and plans?

6. Productivity: Is the patient able to accomplish a satisfactory amount? Is the end product adequate in terms of energy expended?

7. Personal neatness: Is the patient generally clean and neat? Is he aware of his personal appearance? Are his personal and social habits acceptable?

8. Activity neatness: Is the patient neat and orderly in performance and activities? Does he put tools and supplies away?

9. Interest in activity: Does the patient manifest any interest in what he is doing?

10. Interest in accomplishment: Does the patient show an interest

in the end product? Does he show pleasure and pride in his accomplishment?

11. Coordination: Are the patient's motions directed and controlled? Can he synchronize his thinking with purposeful and efficient movement? Does he possess a kinesthetic rhythm during participation?

12. Concentration: Can the patient apply himself to a given task without losing interest readily? Are his interest and endeavor sustained? Can he work through or think through a problem?

13. Performance standard: Does the patient set high standards of workmanship and accomplishment? Does he demand that most endeavor be directed to perfection? Is he critical of his own performance?

14. Skill: Does the patient possess manipulative ability and manual dexterity? Does he possess the ability to perform an activity proficiently, with knowledge and readiness?

15. Decisiveness: Is the patient able to make reasonable choices and decisions? Can he come to a logical conclusion? Is he determined, resolute?

In instances where a written note is preferred, the following list of questions may provide a guide in recording information:

1. *How does the patient behave toward you?*

a. Does the patient show an unfriendly attitude toward you? In what way?

b. Does he reject or oppose your directions and suggestions? Does he refuse to follow directions when he is able to do so?

c. Does he seem to do the opposite from what he is told? Does he ask and wait for instructions and then proceed in an opposite manner?

d. Does the patient seem to rely on you for decisions, actions, and directions? Does he seem to lean on you and expect you to tell him everything to do?

e. Is it difficult to approach the patient because he is shy, withdrawn? Does he require coaxing and encouragement?

f. Does the patient follow rules and procedures, or does he make

demands on you, always asking for attention from you and the other patients?

g. Is the patient responsive; is he easy to approach and get to know? Is he open to influence and reason?

h. Is the patient trustworthy, reliable? Can he usually be depended on to perform in an acceptable manner?

2. *How does the patient behave toward the group?*

a. Does the patient contact and work with other patients? Is he friendly, pleasant with other patients? Does he talk to others?

b. Does he take the lead in the group, such as attempting to organize it or getting other patients to participate?

c. Does he follow other patients' lead in working rather than being the leader or instigator? Does he seem to prefer to follow and conform to group organization?

d. Does the patient show in his conversation or behavior a desire to do better than the other patients? Does he compete with others for your attention or the group's?

e. Does he seem to criticize other patients, find fault, complain about them?

3. *How does the patient react to the activity?*

a. Does the patient readily understand directions; does he learn easily, and is he able to follow these directions once they have been given? Is he able to remember from one day to the next what he has been taught?

h. Is he energetic; does he work with industry and with a purpose?

c. Does he show initiative? Can he see things to be done without being told and go ahead with them?

d. Is he able to accomplish a satisfactory amount of work, or does he use up a great deal of energy and get nothing done?

e. Is the patient generally neat and clean? Does he seem to be aware of his personal appearance? Does he work in a neat, orderly fashion?

f. Does he show interest in what he is doing? Does he seem to be interested in how much he accomplishes? Does he take pride in his performance?

g. Can the patient apply himself to a given task, or does he soon lose interest?

h. Does the patient seem to set high work standards for himself? For others? Does he want his work to be perfect? Does he criticize his own performance?

i. Does the patient show skill and ability in what he does? Does he seem to have any special skill or ability?

j. Can the patient make good, logical decisions? Can he decide what to do without too much help and guidance?

k. Does he seem to attempt many things at the same time? Is he always in a hurry, accelerated, hyperactive?

REFERENCES

AZIMA, H.: "Dynamic Occupational Therapy," *Dis. Nervous System,* Vol. 22, No. 4, 1961.

BALES, ROBERT F.: *Interaction Process Analysis: A Handbook for the Study of Small Groups.* Cambridge, Mass.: Addison Wesley Pub. Co., 1950.

BECK, SAMUEL J.: *The Rorschach Experiment.* New York: Grune & Stratton, Inc., 1960.

GIBB, JACK R., PLATTS, GRACE N., and MILLER, LORRAINE F.: *Dynamics of Participative Groups.* St. Louis: Swift and Co., 1951.

HUBER, JACK T.: *Report Writing in Psychology and Psychiatry.* New York: Harper & Bros., 1961.

MILNER, MARION: "The Communication of Primary Sensual Experience," *Internat. J. Psychoanal.,* Vol. 37, No. 4–5, 1956.

PHILLIPS, WILLIAM (ed.): *Art and Psychoanalysis.* New York: Criterion Books, 1957.

RUESCH, JURGEN: *Disturbed Communication.* New York: W. W. Norton & Co., Inc., 1957.

CHAPTER 9

Occupational Therapy as a Treatment Process

Several concepts are basic to the consideration of occupational therapy as a treatment process. These have been mentioned in the earlier chapters of this book; however, they are of sufficient importance to warrant repeating at this time. Perhaps the first and most important is a definition of treatment. We have defined treatment as those processes that are consciously and scientifically directed toward the delineation and correction of pathology. Treatment, then, requires a body of scientific knowledge sufficient to enable one to (1) delineate pathology, (2) make reasonable predictions on the basis of this, (3) plan a course of treatment, (4) recognize and understand what is occurring psychodynamically during treatment, and (5) be able to use and influence what occurs to the benefit of the patient.

Second, implicit in considering occupational therapy as treatment is the concept of the phenomenon of the unconscious. Recognition and understanding of unconscious proc-

esses within oneself as well as within the patient are fundamental to psychiatry and must also be fundamental to psychiatric occupational therapy. Effective use of the one-to-one or group relationships and activities in treatment can occur only to the extent that one has an understanding of the impact of the unconscious.

Third, the unique value of occupational therapy lies in the use of the psychodynamics of activities. Utilization of the real and symbolic significance of object relationships and activities marks the major contribution of occupational therapy in treatment and differentiates it from interview psychotherapy. It is a therapeutic process that relies heavily on the significance of nonverbal communication. There are, of course, large areas of similarity and overlap and common theoretic constructs with psychotherapy. However, in occupational therapy the psychodynamics of activities are considered as catalytic agents giving impetus to the development of relationships and intrapsychic experiences, which are used by the therapist and patient collaboratively to alter and eliminate pathology. On the basis of this concept, then, the nature of the process rather than the end product is of primary importance. By process we refer to the stimuli of the real and symbolic meaning of an object or activity, the intrapsychic responses of the patient to such stimuli, the pervading influence that such feeling, thinking, and acting has on interpersonal relationships, and the collaborative efforts and communication between patient and therapist. The finished product, or what is made, in occupational therapy then has significance only as it reflects or symbolizes this process.

Treatment is a dynamic, ever-changing process. As partic-

ular needs and problems of the patient are worked through, various aspects of the occupational therapy experience will assume varying degrees of importance. For example, those experiences that may be perceived as providing gratification for basic infantile needs may at a certain time be given priority over experiences that provide for reality testing, reestablishment of defenses, etc.; whereas in another instance opportunities for consensual validation and ego support may assume greater significance. The value placed on various aspects of the occupational therapy experience will vary according to the theoretic concepts concerning treatment. Thus, although all components of the occupational therapy experience have an impact on the patient, focus of attention on any one aspect at any one given time will be determined by the emergent pathology, the particular philosophy of treatment, and the therapeutic goals and methods determined within a given philosophy. As we have indicated in the Preface, it is not our purpose to present formulations as proponents of any one specific "school of thought." Our aim is rather to define some of the more basic characteristics of occupational therapy in order that these may be comprehended and translated into use within various theoretic frameworks.

Within this frame of reference, then, we would like to summarize those formulations presented earlier in this work that constitute experiences accrued from the combined use of the psychodynamics of activities and relationships. Again, it must be emphasized that these therapeutic goals or experiences are not limited to or unique with occupational therapy but rather that the use of activities does appreciably enhance such experiences.

1. Providing a means of expressing and uncovering unconscious needs, drives, and feelings and of dealing with these in the indicated manner.

2. Providing a means of gratifying needs either directly or by sublimation.

3. Strengthening ego defenses by assisting the patient to re-establish previous defense mechanisms in a more constructive manner and to learn new satisfactory defenses.

4. Providing ego growth through opportunities to work through distortions in self-concept and body image and to enhance the sense of personal identity and worth.

5. Providing reality testing through the opportunity to explore and test perceptions, to distinguish reality from fantasy, and to experience consensual validation and agreement on the nature of reality.

6. Exploring interpersonal relationships through opportunities to enter into one-to-one and group relationships, to explore these, to work through interpersonal distortions, and to share and communicate with others on a verbal and nonverbal level.

7. Consolidating gains through continued experimentation, validation, and communication in an environment of thinking, feeling, and action. Providing opportunity to test one's developing skills in living.

Traditionally, the occupational therapist sees patients in groups. Unfortunately, in many instances the size of these groups or the number of patients with whom the occupational therapist is expected to work makes it impossible or at best extremely difficult to become involved in treatment. When occupational therapy functions as a treatment process, the group size should be expected to conform to those of

other therapy groups. In addition, sufficient freedom must exist to see patients in individual sessions when this is indicated, as well as to establish criteria for selection of patients.

Another matter of particular significance is collaboration and communication with other clinical staff members. The ultimate effectiveness of any worker may certainly be measured by the nature and extent of his communication with others who are involved with the patient. Likewise, the value of occupational therapy in any setting will ultimately be determined by the nature of relationships and communication with other staff members. This means, then, that the occupational therapist must share responsibility for developing professional relationships built on mutual respect and understanding that maximize the sharing of information and the exchange of ideas and opinions.

Prior to the beginning of treatment with each patient, it is essential that the occupational therapist, the clinical staff, and particularly the patient's individual psychiatrist or psychotherapist thoroughly discuss the inherent problems and treatment plans. The role and function of the occupational therapist must be clearly understood and defined in each individual instance, particularly among those who are working closely with the patient, and the occupational therapist must assume appropriate responsibility for giving impetus to this collaborative effort. As treatment progresses, constant verbal communication is necessary in order that original ideas and plans as well as the ongoing process may be reevaluated and assessed. When occupational therapy is used in conjunction with psychotherapy, such communication becomes even more vital in order that there be agreement on

goals, methods, and procedures as well as constant assessment of process by both persons involved with the patient.

We have selected three examples of how occupational therapy may function as a treatment process. The first describes the long-term, intensive treatment of a severely regressed, mute, chronic schizophrenic girl. This case example illustrates how activities were used (1) to gratify basic infantile regressive needs, (2) as nonverbal communication in developing the therapeutic relationship, (3) as a means for expressing unconscious needs and drives, and finally (4) as a springboard to verbal communication and a working through of some of the patient's more basic problems in feeling, thinking, and functioning.

Mary, a 24-year-old single woman, had shown symptoms of a moderately severe catatonic schizophrenia for six years. She was adopted at the age of six months, and according to her parents, her early development was entirely normal. They described Mary as a healthy, popular, and industrious child. During adolescence she was extremely popular with the boys, and this brought the first suggestion of family disapproval. Her mother became extremely critical, and the father, who was more permissive, encouraged the girl to discuss her sexual experiences with him. The father, a college professor, is described as compulsive, perfectionistic, and highly competitive with recurring depression. The mother is described as an equally hard-driving "career woman."

At the age of 15 years, Mary was sent on an extended vacation in an attempt to interrupt steady dating with a boy whom her family found unacceptable. Upon her return, the patient refused to go back to school, thought of entering a

convent, and became increasingly withdrawn and preoccupied with the subject of death. She first entered therapy at this time on an outpatient basis but became increasingly autistic and was finally hospitalized. She received electroconvulsive therapy but continued to be mute and withdrawn and was transferred to the present hospital.

Psychotherapy was extremely difficult with Mary because of the remarkably total "echo" phenomenon she presented. With a mocking smile she would repeat all the therapist's movements and words, adding nothing of her own. This behavior finally subsided and was replaced by what might be called a state of friendly mutism. This defense continued for many weeks and was finally broken when her psychotherapist engaged her in a game of Ping-pong. However, communication was not sustained, and the patient became more withdrawn, ruminative, and defiant. A change in psychotherapist altered the pattern for a brief period of time, but again Mary became mute, negativistic, and extremely withdrawn.

Many attempts had been made to involve the patient in occupational therapy, and she did attend several sessions with a group during her brief periods of symptomatic relief. However, the nature and severity of her illness made it impossible to reach this girl in the more typical occupational therapy setting. Approximately one year after admission, the occupational therapy staff was asked to review the problem for the purpose of considering intensive treatment for Mary. There was a consensus "that conventional verbal techniques were not resulting either in therapeutic contact or adequate history taking." [1] It was agreed that intensive treatment in

[1] Jewitt, Robert, and Fine, Susan: "A Case in Point: Intensive Treatment in Occupational Therapy." Unpublished paper.

occupational therapy was indicated as the primary psychotherapeutic process for this patient because of her inability to communicate on a verbal level and because of her severe regression. It was further agreed that the patient would be seen daily by the occupational therapist, that the psychotherapist and occupational therapist would work in close collaboration, and that together they would have regular supervisory sessions with a supervising analyst.

At this time Mary's behavior was characterized by a refusal to eat or to dress, aimless wandering on the ward or withdrawal to her bed, mutism, incontinence, and inappropriate giggling and grimacing. The patient was seen on the ward by the occupational therapist for approximately one-half hour each day. These initial sessions were devoted to sitting quietly with the patient, reassuring her about the occupational therapist's desire to help, and offering her candy, cookies, or chewing gum. Gradually Mary began to anticipate these visits, getting out of bed and finally waiting by the door or on the ward for the occupational therapist. She continued to be mute and withdrawn but would respond more spontaneously in a more positive manner when food was offered. Gradually the patient was able to leave the ward with the occupational therapist, spending brief periods of time in the occupational therapy room and going for walks out of doors. The occupational therapist functioned as a protective, gratifying mother. Regressive behavior was accepted and the patient was encouraged to express her infantile needs and to gratify these. She was given food, soda, and milk and was helped to dress, wash, and comb her hair, and every opportunity was utilized to gratify Mary's infantile dependency needs.

As Mary became more secure in her relationship with the

occupational therapist, she was able to spend longer periods of time in the occupational therapy room. Here she was encouraged to experiment with paints and clay. This was considered important, not only to gratify regressive needs, but to provide opportunity for communication, since she continued to be essentially mute, and to elicit material that would be of help in better understanding some of the problems this girl was experiencing. Originally, there were only rare attempts at drawing or constructing real objects, and Mary would spend the time smearing colors on paper, squeezing clay, or drawing a series of disconnected lines. The occupational therapist verbalized to the patient her impressions of what the patient seemed to be feeling and what seemed to be going on between them. Mary responded with body movements and action or by clicking her tongue and only occasionally and gradually began to use words in response.

During this time Mary's psychotherapist continued to see her for brief but regular meetings. Mary continued to be unable to communicate in these sessions, and they were used to reassure her and support her developing relationship with the occupational therapist.

Eating with or being fed by the occupational therapist was particularly meaningful to Mary. During these experiences she began to reveal some of her feelings about herself, her confusion about her identity, what it meant to be fed, to be "mothered," and some of the angry and "scary" feelings this elicited for her. Her ambivalence and confusion concerning her experiences with the occupational therapist were evident in many instances. At one point she cried, "What is happening to me? Why don't you leave me alone? Don't leave me alone!" Mary also evidenced considerable confu-

sion about her identity and body image and had difficulty distinguishing between herself and others, her feelings and external stimuli. She seldom used "I" when referring to herself but used "Mary" or would respond more typically with, for example, "you—no—I mean two of me—no—you and Mary." At this time she attempted to draw figures rather than the fragmented lines and colors she had been producing. During these sessions she talked about wanting "to get to the center of the earth" where she could "get everything I need." Her evaluation of her needs was "a head, a body, arms, mind, eyes, mouth."

Ultimately, Mary began to be able to talk to her doctor about her feelings and her experiences with the occupational therapist. In the occupational therapy sessions she was able to talk more freely about her feelings, particularly in relation to her parents and the fear that such hostile, aggressive feelings elicited for her. These sessions continued to be directed toward further exploration and working through of these major conflicts as well as dealing with many of her body distortions and confused identity. Development of ego strength and body image concepts was consolidated by visits to the hairdresser, help in using cosmetics, assistance in the selection of clothing, and attendance at selected group social functions. All these experiences occurred in the company of the occupational therapist. At this time, in addition to the individual sessions, Mary was placed in an occupational therapy group, where she was supported and helped in her beginning experimentations of relating to and interacting with others.

During all this time the social service worker had been working with the family and discussing with both the doctor and the occupational therapist progress in this area. The oc-

cupational therapist and doctor had met several times with the parents and the social worker. At this point Mary was able to make brief visits to her home both alone and with the occupational therapist, and her capacity to evaluate her feelings in this respect increased rapidly.

After two years, Mary is living with her family several days of each week and continues her individual and group sessions in occupational therapy. She has become a contributing, productive member of this group as well as of the hospital newspaper group and is working in the hospital coffee shop.

The second example describes the treatment process of a pseudoschizophrenic or severely psychoneurotic woman, dealing essentially with problems of identity and demonstrating how action and objects were used to (1) elicit feelings and ideation, (2) increase awareness and understanding of these, and (3) develop a meaningful and satisfying relationship from which would emerge a realistic and gratifying self-concept and identity.

Susan, a 20-year-old woman, was admitted to the hospital after several quite mutilating suicidal attempts. She is an only child who has had an extremely close relationship with her father, was distant with the mother, and rejected most peer relationships. From the history, it is reasonable to assume that the daughter-father relationship was characterized by quite seductive behavior on the part of the father. The mother is an extremely attractive, cold, removed person who has always been more concerned about how Susan looked and behaved than about her needs and feelings.

Immediately prior to Susan's suicidal attempts, her mother was hospitalized for surgery and her father began having

an affair with another woman, bringing the woman into the house and acting out in front of Susan. The patient then acted out sexually with a boy in the neighborhood, and the neighborhood reacted with overt anger and indignation. The father's response to this was, "What has gone wrong between us?"

Upon admission, Susan talked only about being a homosexual and made many awkward attempts to kiss and hold hands with the female patients and student nurses. Attempts at self-destruction continued, and she remained essentially uncommunicative, withdrawn, and resistive to psychotherapy, refusing to keep her appointments. In occupational therapy she was seen with a small number of other patients, remaining aloof and uncommunicative, withdrawing to a small corner, and painting in a compulsive manner. Her drawings showed depression and feelings of loneliness, futility, abandonment, and fear. Both her drawings and her behavior served to ward off any relationships with either the occupational therapist or her group, and it was impossible, at this time and in this setting, to reach her. After approximately eight months with no improvement, it was decided that the occupational therapist should work with her intensively in individual sessions.

The patient's drawings were used as a primary method of communication, and gradually in the security of the one-to-one relationship Susan began to be able to talk about feelings related to her action. For example, she discussed a picture of two figures with both masculine and feminine characteristics kissing, a clay piece of a mother and child, and a clay head turned away with eyes closed. At this time she began to make attempts to kiss and touch the occupational therapist and would become quite frightened and talk

with panic about being a homosexual after such touching occurred. Again her creative art was used to explore with her the meaning of these actions and feelings. At this time she would vacillate between quite infantile, dependent behavior and awkward, "seductive" behavior. She stated one day, "I am not sure whether you are my lover, my friend, or my mother." What each of these meant to her was explored as were her concepts about herself and the expectation she had concerning relationships.

At this time she was able to keep her appointments with her male psychotherapist but was extremely guarded, evasive, and uncommunicative. She expressed many vague fears and acute anxiety to the occupational therapist about the psychotherapy sessions and began to talk about her ideas that sexual activity was implicit in any contact with a man. She was ultimately able to state that she felt simply looking at a man was symbolic of the sexual act. During this time she would keep her eyes closed whenever men were near her and began wearing dark glasses. A correlation between her suicidal attempts and these experiences and feelings was determined.

The occupational therapist and Susan began to cook meals and eat together, and gradually, within the security of this relationship, the patient was able to accompany the occupational therapist on walks and brief shopping trips. Her behavior became increasingly dependent and more infantile, and she dropped the subject of the occupational therapist's being a lover, talking more about whether she was a friend or a mother. She began asking questions about sex, menstruation, dating, etc., and their excursions together served as excellent opportunities for Susan to witness the behavior and relationships of the occupational therapist to men and were

used to discuss the fact that such encounters did not lead to destructive sexual activity.

They began to include the doctor in a few of the trips into town, and Susan and the occupational therapist cooked dinner for him. It was at this point that Susan stated, "I wish I could be reborn, be a baby and have you and Dr. —— as my parents."

Gradually there began to be evidence of Susan's identification with the occupational therapist. She began wearing her hair in the same fashion, dressing like her, talking about wanting to become an occupational therapist, and helping other patients in the group, to which she had returned. The turning point in Susan's growth and development came when she decided to knit a sweater for herself. The sweater was bright yellow and served to show her body rather than to hide or cover it, as she had previously done. She was encouraged to recognize the importance of her narcissistic needs and to indulge these. She began to ask many questions about the occupational therapist's personal experiences and was able to talk about these in relation to her fears about men and sex.

Using this identification, the occupational therapist helped her to look at some of her own assets and abilities, and Susan began to become aware of the differences between herself and the occupational therapist. She would remark, "I couldn't do this," or "This is not like me," and, finally, "I am not really like you—I'm me." Susan is now exploring the "me."

Finally, the third example is a brief attempt to show how occupational therapy may function in conjunction with group psychotherapy. This therapy group is composed of eight female patients, a doctor, social worker, nurse, and occupational therapist and meets regularly three times a week. In addition, the patient group is seen by the occupa-

tional therapist four times a week for one-and-one-half-hour sessions. Generally, each patient has been free to choose his own activity since it was felt that both the method and nature of selection would produce valuable material with which to work. The occupational therapy sessions have been used to help the patients become aware of their feelings, using their nonverbal action language for the beginning of awareness. Feelings that are thus elicited have been more thoroughly discussed in the group therapy sessions. For example, one patient who had denied angry feelings and had been unable to accept the group's interpretation that she was angry was able to experience such feelings as she aggressively wedged clay and could then begin to talk about this in the group. The occupational therapy experiences have also been used to help the patients become aware of the consistency and relatedness of their behavior in different settings. Behavior in occupational therapy is explored and used to increase the patient's awareness and understanding of how and why he behaves in certain situations and of the consistency of such behavior and feeling as well as variations—for example, the patient who needed structure and control but could not accept them in occupational therapy and failed because she was unable either to follow a pattern or to work things out for herself or who would ask for rules or patterns and then deviate to the extent that failure was inevitable; or the patient who in group therapy warmly denied dependency needs and then created a mother and infant form in clay; or again the patient who manipulated others into rejecting her and would attempt to involve the occupational therapist in an investment in her project and then either destroy it or be unable to complete it.

Each of these incidents, then, is pointed out by the occupational therapist and other patients as it occurs and by

and large forms the basis for discussion in group therapy.

In addition, the occupational therapy sessions are used to consolidate insights and awarenesses that have occurred and give the patients an opportunity to experiment with the gains they have made. Thus the patient who has gained sufficient ego strength to experiment with new-found self-assertiveness is encouraged to act in this way in occupational therapy. Likewise, other patients have been supported in acting out their feelings and ideations. The collaborative working and doing atmosphere provides an excellent opportunity for patients to become aware of their feelings with regard to sibling rivalries, competition, failure, maternal dependency, authority, and many other problems. These feelings are discussed and provide impetus to further exploration in the group therapy sessions.

REFERENCES

ARIETI, SILVANO: "Psychotherapy of Schizophrenia," *Arch. Gen. Psychiat.*, Vol. 6, No. 8, 1962.

AZIMA, H., and WITTKOWER, E. D.: "Gratification of Basic Needs in Treatment of Schizophrenics," *Psychiatry*, Vol. 29, No. 2, 1956.

FROMM-REICHMAN, FRIEDA: *Principles of Intensive Psychotherapy.* Chicago: University of Chicago Press, 1950.

———: *Psychoanalysis and Psychotherapy.* Chicago: University of Chicago Press, 1959.

NAUMBERG, MARGARET: *Psychoneurotic Art: Its Function in Psychotherapy.* New York: Grune & Stratton, Inc., 1953.

SECHEHAYE, M. A.: *Symbolic Realization.* New York: International Universities Press, Inc., 1951.

SULLIVAN, HARRY STACK: *Schizophrenia as a Human Process.* New York: Basic Books, Inc., 1962.

WILL, OTTO ALLEN: "Process, Psychotherapy and Schizophrenia," in BURTON, ARTHUR (ed.): *Psychotherapy of the Psychosis.* New York: Basic Books, Inc., 1961.

CHAPTER 10

Occupational Therapy in Relation to Mental Health Processes

It has been said that while the first half of the twentieth century would be marked as the era of fruition of psychoanalytic concepts in treatment, the second half of this century would be recognized as the era of social psychiatry. Certainly current literature would seem to validate such a prediction. Increased research in social psychiatry has heightened the appreciation of the hospital system as a factor in dealing with mental illness. Studies done by Stanton and Schwartz,[1] Caudill,[2] and others [3] have given impetus to increased investigation into the nature and extent to which the process of mental illness may be modified or relieved by occurrences or events within the social system of a hospital.

[1] Stanton, Alfred H., and Schwartz, Morris S.: *The Mental Hospital.* New York: Basic Books, Inc., 1954.

[2] Caudill, William: *The Psychiatric Hospital as a Small Society.* Cambridge, Mass.: Harvard University Press, 1958.

[3] See bibliography, pp. 256–57.

Students of sociology are quite familiar with Henderson's [4] "rubber-band theory." This theory attempts to show the interdependence of all forces within a social system by visualizing all persons within a given system as attached to one another by rubber bands. Any movement or change in any one person, then, will create movement in all others. Such a way of thinking makes explicit the reciprocal impact of organization, action, communication, decisions, etc. This theory also lends further understanding to the phenomenon of resistance to change in that the rubber bands tend to return to their "normal" position, exemplifying a system's tendency to maintain a standard and routine position.

We have said that mental health processes, such as the therapeutic community, milieu therapy, and others, are based on recognition of man's normal basic needs and inherent rights and are directed toward creating an environment that maximizes gratification of these needs and exercise of these rights.

We have emphasized that one's attitudes toward patients and associates must be based on an inherent belief in the integrity and worth of the human being, recognizing that certain basic needs are common to all men and that satisfaction of these needs is essential to existence. Those basic needs that must determine the structure of program planning and the function of all persons within such a structure may be generally described as

1. Need for love, acceptance, and a sense of belonging.
2. Need to perceive oneself as an individual distinct from others.
3. Need to be self-determining, to exercise some free will.

[4] Henderson, Lawrence J.: *Pareto's General Sociology*. Cambridge, Mass.: Harvard University Press, 1937.

4. Need to experience a mutual, sharing, collaborative relationship with one's fellowmen.

5. Need to experience consensual validation.

6. Need to perceive oneself as a productive, contributing member of society.

A review of these should serve to point up the significance of communication, staff relationships and roles, attitudes about patients and their roles, organizational and administrative aspects, and, in fact, all events that occur within a hospital. In addition, it becomes obvious that the attitudes of the community outside the hospital influence staff and patient attitudes as well as program structure and implementation. One needs also to understand the extent to which institutions, by the nature of their structure and functioning, tend to deny the patient opportunities to fulfill these needs. Irving Goffman's [5] study in this area gives one a better awareness how and why this occurs. As one looks at the organizational procedures, admitting policies, decision making, regimentation, and conformity that have been the accepted routine in many institutions, one may begin to perceive the extent to which basic individual needs of the patient have been frustrated. The report on the research project devised and implemented at Massachusetts Mental Health Center deals with many of the inherent problems encountered in institutions and describes the creative and exciting program of change.[6] It is not feasible in a work of this nature to attempt to cover the multiple sociologic theories that impinge

[5] Goffman, Irving: "The Total Institution," in *Identity and Anxiety: Man's Struggle for Survival in Mass Society.* Glencoe, Ill.: the Free Press, 1960.

[6] Greenblatt, Milton; York, Richard; and Brown, Esther Lucille: *From Custodial to Therapeutic Patient Care in Mental Hospitals.* New York: Russell Sage Foundation, 1955.

on function in this area. We can only emphasize the necessity for developing an understanding and working knowledge of these concepts.

Communication is vital to the very existence of any system in which human beings are involved. We know this to be so, and professional literature is replete with explorations of the problems and issues that make communication difficult. For almost two decades, the term "team approach" has been extensively used. Those who are involved over a period of years in attempts to work within this concept ultimately come to realize that in many instances it has continued to remain a concept rather than become a reality. It has taken many years and the active involvement of the social scientist and the social psychiatrist to help us begin to understand the nature of some of the blocks to more meaningful collaboration between disciplines.

Analysis of hospital social systems has led to a beginning of appreciation for the multiple and complex patterns of communication, interaction, organization, and role concepts that have an impact on patient care and treatment. Communication is a many-faceted problem with its implications in regard to attitudes toward self and others and interpersonal relationships and may be viewed as the very structure on which programs may either succeed or fail.

In the process of finding a niche for oneself—a role in an institution, a function in medicine—and of sustaining or defending this position, one inadvertently creates and sustains barriers to reciprocal communication. The dynamics of this process is as simple and complex as the human being and the society in which he lives. Most of us have some familiarity with the many studies concerning the meaning of status, role definition, status systems, communication pat-

terns within these systems, and the impact of these on both staff and patients. The complexities of institutional systems, professional alliances, and responsibilities for patient welfare and treatment make communication difficulties inevitable, but hopefully, as we are better able to understand the nature of these problems, we will be able to move toward their resolution.

Dr. Maxwell Jones's [7] experiments in creating a therapeutic milieu or environment did much to stimulate thinking and investigation in this area. Hospital programs directed toward the development of a therapeutic environment are concerned with organization and procedures that afford the most opportunities for self-respect, security, and the achievement of satisfaction for each individual patient and for each staff member. Each individual must be encouraged to feel that his activities are of consequence, not only to himself but also to other patients and other staff personnel. Each person must have and give enough communication and understanding so that a change in goal of a staff member or a change in pathology of a patient will bring an adequate and prompt response from others. Communication patterns, both formal and informal, must provide for all levels of staff and patients to have sufficient and appropriate access to one another so that awareness of changes, anxieties, feelings, etc., among individual members may occur and be sufficient to deal with these. Each member must be helped to feel that he has a vital contribution to make and that he has a responsibility to make such contributions as an essential, active participant. Relationships, interaction, and communication must be such as to lead to consensual validation and agreement rather than

[7] Jones, Maxwell: *Social Psychiatry: A Study of Therapeutic Communities.* London: Tavistock Publications Ltd., 1952.

arbitrary or authoritarian decisions. A sense of engagement, mutual respect, and trust must exist in order that each member may share in decision making to an increasing extent as such decisions influence his living and functioning. Finally, all levels of staff need to realize that their efforts, ideas, and aspirations transcend their job definitions.

Knowledge of sociology, psychology, and psychiatry should not only enhance one's capacity to implement such concepts and goals but, hopefully, should also increase one's skill in determining the impact of a given pathology on such expectations as well as the influence that such a frame of reference may have on a given pathology. Such programs imply changes in communication patterns, staff and patient roles, decision making, and many other standard concepts and procedures. Programs directed toward increasing the therapeutic aspects of environment are many times in conflict with the more accepted conventional methods of organization, operation, and treatment. Any set of concepts or procedures that deviates from accepted practice or thinking frequently creates feelings of anxiety in those involved in such change. The occupational therapist is not exempt from these anxieties and may find himself many times in a dilemma concerning his individual role and function as well as the fundamental philosophy of his profession.

The influence of change in attitudes and concepts concerning the care and treatment of the mentally ill has been felt by all professions and is evident in the continuing attempts on the part of these groups to define more adequately their role and function. In order for occupational therapy to be able ultimately to assume its rightful responsibility in this area, it is essential that some attitudes and concepts be

reassessed and possibly redeveloped. Those which we perceive as having priority are the following:

1. *An increased ability and willingness to transcend conventional "role concepts."* This requires perceiving any and all functions and activities in the hospital social system as having inherent therapeutic potential. In this sense, then, function should be so defined as to both expand and enhance potential and contribution. This implies a mutual sharing and exchange of roles, skills, and responsibilities with others on the basis of program needs rather than the more conventional definition of roles. Thus, the occupational therapist must assume responsibility for working with others to decrease those sharp delineations of disciplinary boundaries that interfere with program needs and to increase opportunities for reciprocal access to each other's special skills and knowledge.

Problems concerning role definition may well be more pertinent for the occupational therapist as one of the newer members of the professional hierarchy. Therefore, one may come to believe that establishing a more clearly defined role with status equal to other professions is essential to existence and, therefore, also vital to good patient treatment. This tenet may have some merit and can be understood as a relatively new discipline's striving toward a recognized professional role within an already well-established system. Too frequently, however, it is forgotten that when role definition is so vital, it is inevitable that one will get caught up in systems of defense of that position and that such defenses may well deter collaborative endeavor and thus undermine real efforts on behalf of the patient. Engagement

in this struggle then makes it difficult to act freely and with imagination on the real challenge of patient treatment and care. Mrs. K.'s (p. 156) early return to the community, the case of Mary (p. 122), and the discussion group (p. 157) are examples of the value of flexibility with regard to role and definition.

2. *A reassessment of the traditional occupational therapy activities.* Activities being used in occupational therapy, as well as the setting in which they occur, need to be re-evaluated in terms of their meaningfulness in a therapeutic community, their purposefulness to the patient, and their reality "in terms of their social-cultural meaning." The emphasis on or priority given to the use of arts and crafts in occupational therapy needs to be reassessed in light of the growing awareness and capacity to discern what is of therapeutic value in the daily living experiences of patients. For example, one occupational therapy department was very concerned about the lack of motivation and investment concerning occupational therapy on the part of a group of male tuberculosis patients. These patients did not respond to a variety of crafts offered them and remained removed, disinterested, and unmotivated. In discussing the problem, it became evident that this group of Filipino men, who had spent their entire lives working in sugarcane fields, could find little that was meaningful or purposeful to them in making leather billfolds or copper enameling. By exploring with this group those activities that had meaning for them, the staff was able to begin to work toward a program in which the patients would have some investment. Likewise, a group of hostile, acting-out adolescent girls were reached only after the occupational therapist was able to discard crafts for a discussion group on cosmetics, clothes, dating, etc.,

and expand this to include instructions in doing the "twist," setting hair, and other aspects of teen-age life that were important to these girls.

These examples serve also to point up the need to become increasingly aware of the value of opportunities for patients to exercise and experiment with their rights to be self-determining. Programs planned as mental health processes must engage the patients in making decisions concerning what is meaningful to them in terms of activities and how such meaningful activity may occur. The extent of such opportunities or expectations will of course vary according to the patient's or group's capacity to exercise such right, although we believe that many tend to underestimate the psychiatric patient's capacity in this respect. The responsibility of the occupational therapist and others is to provide the atmosphere and attitudes that will support the patient in such experimental experiences. The role of the occupational therapist as a supportive group leader thus becomes highly significant and needs further exploration and study in the development of such skills.

3. *An increased sense of responsibility for creative leadership and participation in the total hospital program planning.* It is necessary to be able to transcend traditional roles to the extent that one can begin to feel some responsibility for what goes on in the hospital outside the walls of the occupational therapy department and to be able to act on this sense of responsibility. Such expectations make it necessary to look at the professional image of oneself and to attempt to understand some of the reasons for such an image. Acceptance of the responsibility for leadership is closely correlated with one's own "professional concept." One can function and be perceived as professional with

essential skills only to the extent that one is able to perceive oneself as such. The basic skills and knowledge of the occupational therapist are particularly valuable to leadership roles in a hospital community. The failure to utilize such potential needs careful study. In one instance, several occupational therapists became quite concerned and complained among themselves about the fact that television sets for patients were placed so high on the walls of the wards that patients could not reach them for program changes. However, they were unable to raise this question at any of the clinical staff or patient meetings. Another group was unable to raise questions about changing smoking rules in certain areas or providing coffee for patients, in spite of the fact that they felt the existing policies were contributing to hostile, negative feelings on the part of the patient group. In another instance, however, numerous changes were effected in ward organization and patient roles because an occupational therapist was able to provide leadership and work collaboratively with others. Productive leadership requires security sufficient to produce a creativity and flexibility relatively free from defense, which enables one to see beyond the confines of a narrow role definition, to reach out to others in a collaborative way so as to elicit their support and enable them to contribute to the fullest their knowledge and skills.

4. *A more active involvement in and understanding of the community outside the hospital.* There is a need to understand the social-cultural forces within the patient's community outside the hospital, how these impinge on both his illness and his health, and thus how program planning can best prepare him to return to this society. This expectation requires a knowledge of the community, its attitudes, re-

sources, and social and economic frame of reference, as well as involvement with the community to the extent that its resources and support may become more readily available. Here again the occupational therapist needs to be able to reach beyond the more conventional delineation of areas and provide opportunities for the outside community and patients' families to become involved in some of the patient's hospital experiences and for the hospital patient to become actively involved with groups in the community outside the hospital. Patients who become members of community clubs and who attend their meetings and participate in them and in organizational functions are one example. In one hospital, the occupational therapy department was able to elicit the help of the social service in bringing together a group of patients and their families in a weekly social event. In another, the arts and crafts festival organized and planned by patients involved family and community members in both planning and implementation. A group of hospital adolescent boys were taken bowling by an occupational therapy student. Their growing acquaintance with the manager of the bowling center led ultimately to their involvement in a boys' club in one of the local churches. In still another instance, a patient club in interior decorating led by an occupational therapy student became involved in the community with others who shared the same interests.

5. *A reappraisal of one's attitudes toward patients and toward mental illness.* It is important to look at some of the problems in feelings about and behavior toward the mentally ill. As we have indicated earlier (p. 49), the needs of persons entering the helping professions may well encourage "sick behavior" on the part of the patient. One's need to perceive

another as sick or dependent in order to gratify a need to be of help or service does occur at times and establishes a set of role expectations in which both therapist and patient may become involved. The tendency to classify patients as "the assaultive," "the worker," "the idler," "the manipulator" is evident in many situations, and the impact of such expectations on patient behavior and ward functioning has been explored by Von Mering [8] and others.

It is necessary to become aware of the many inconsistencies in attitudes and behavior and to increase one's understanding of the unconscious attitudes that perpetuate these inconsistencies. For example, one may speak of needing to trust the patient but lock up all tools and supplies, or state one's belief in the value of close interpersonal relationships and at the same time caution against becoming involved or getting too close to the patient. Signs on the walls of an occupational therapy room that list multiple do's and don't's or give instructions or reminders certainly cause one to raise questions about belief in the value of reciprocal communication and interaction or in the capacities of patients.

6. *A constant reassessment of what one perceives as the real and meaningful needs of others.* There must be a concern for differentiating one's own needs from the patient's needs. Because one finds certain activities or experiences meaningful to oneself, it is often easy to make the mistake of assuming that others will also need or be gratified by similar experiences. While one may feel he knows what is best for the patient, it does not necessarily follow that the patient should or will accept this as valid or meaningful.

[8] Von Mering, Otto, and King, Stanley H.: *Remotivating the Mental Patient.* New York: Russell Sage Foundation, 1957.

Successful involvement with the patient will depend on one's appreciation for the differences and discrepancies between one's own set of values and those of the patient. Such differences may extend even to the concept of the value of activity or action itself. It is important for the occupational therapist to be aware of this and to be able to assess constantly what may have meaning for a given patient and why this may be so. A nurse sought the help of an occupational therapist in attempting to motivate a patient toward more activity and involvement. Both the nurse and the occupational therapist became concerned because the patient refused many of the activities available, did not want to come to occupational therapy, and spent most of her time in her room or on the lawn reading. When the problem was explored, it was learned that this 85-year-old woman had spent a busy and active life working to raise and educate 12 children. In speaking about her reading, the patient said, "All my life I've waited for time to explore these wonderful worlds." Now she felt she had at last found time to indulge herself and was thoroughly enjoying the experience. The occupational therapist's spending some time talking to this woman about her reading and continuing this discussion during short walks around the grounds provided her with the additional gratification of being able to share her learning and enthusiasm. One could well understand how meaningless other activities were at this time for this patient.

7. *A re-evaluation of one's means of communication and one's attitudes concerning these.* One needs to look at how one communicates, the techniques used, and the rationale for these and to explore more satisfactory ways of communication. Achieving effective communication requires considerable effort by all persons. The ability to communicate with

efficiency and gratification develops from many attitudes, concepts, and skills, which have been previously discussed. Improved communication, then, depends on growth and development of skills and knowledge in all areas of professional functioning, as well as practice in specific communication skills. The occupational therapist needs not only to become more aware of particular problems in communication but also to investigate these toward understanding them and the extent to which they may be particular either to persons entering this profession or to the profession itself.

Essentially, professional growth in these areas may be evidenced by increasing capacity to move beyond the familiar—to respond to and be concerned more with experimentation and exploration and less with needing to be cautious, defensive, or at all times right; to share goals and thinking with others and to appreciate that similarities may well be the real source of meaningful, collaborative effort; to be constantly curious—asking why and feeling free to explore the problem and to act on the implications of whatever answers one may find; to dare to think and to have the courage to face the responsibilities inherent in creative thinking; to accept the patient and his needs as the only real and vital reason for existence of the profession.

ADDITIONAL REFERENCES

ARTISS, KENNETH L.: *Milieu Therapy in Schizophrenia.* New York: Robert Brunner & Co., 1962.

CAUDILL, WILLIAM A.: *The Psychiatric Hospital as a Small Society.* Cambridge, Mass.: Harvard University Press, 1958.

ENSLOW, ALLEN J.: "The Environmental Treatment of Psychosis," *Psychiat. Quart. Supplement,* Vol. 26, 1952.

GREENBLATT, M., LEVENSON, B. J., and WILLIAMS, R. H.: *The Patient and the Mental Hospital.* Glencoe, Ill.: The Free Press, 1957.

GREENBLATT, MILTON, YORK, RICHARD H., and BROWN, ESTHER LUCILLE: *From Custodial to Therapeutic Patient Care in a Mental Hospital.* New York: Russell Sage Foundation, 1955.

JONES, MAXWELL: *The Therapeutic Community: A New Treatment Method in Psychiatry.* New York: Basic Books, Inc., 1953.

RIOCH, D. MC K., and STANTON, A. H.: "Milieu Therapy," *Psychiatry,* Vol. 16, No. 1, 1953.

CHAPTER 11

Occupational Therapy—Its Role in Rehabilitation

It is evident that interest in the rehabilitation of the mentally ill has increased markedly in the past few years. The success of drugs has had its impact on attitudes concerning the reversibility of the process of mental illness and has made more patients available for both treatment and rehabilitation. The involvement of the sociologists in the field of psychiatry as well as the increased communication between American and European psychiatry has given further impetus to such programs.

As one reviews the literature in this area, it becomes evident that concepts regarding rehabilitation in psychiatry range from vocational placement and training to almost all aspects of treatment and programming. We have offered a definition of rehabilitation stating that in essence it is concerned with the development or improvement of specific skills and capacities that may be directly related to successful economic and social functioning in the community out-

side the hospital. Within this frame of reference, occupational therapy is related to rehabilitation to the extent that it is able to make specific contributions in assisting the patient to bridge the gap between hospital and community and to sustain satisfactory functioning in that community. Just as occupational therapy is one small part of the total rehabilitation effort, so rehabilitation is only one portion of the role and function of occupational therapy.

Certainly the psychologic importance of work to the human being is unquestionable and has been evaluated and tested by industrialists, sociologists, psychologists, and many others. Rehabilitation, however, is significant not only because of the psychologic impact of work but also because in our culture it is man's source of preservation and livelihood. However, in a survey study sponsored some few years ago by the National Association for Mental Health, it was reported that in most instances former psychiatric patients broke down in their work adjustment because of difficulties in social skills and relationships on the job rather than because of lack of technical skill or training. Such data certainly point up the need for increased study in this area of work adjustment.

The *Objectives of Occupational Therapy*, published by the American Occupational Therapy Association, provides some definition of the relationship of occupational therapy to rehabilitation. Many of the more meaningful concepts inherent in these definitions were explored at a conference sponsored by the American Occupational Therapy Association and published in the proceedings of this conference.[1]

[1] West, Wilma (ed.): *Changing Concepts and Practices in Psychiatric Occupational Therapy.* American Occupational Therapy Association, 1959.

Any involvement in a program of rehabilitation necessitates an awareness and working knowledge of the social, cultural, and economic structure of the community to which a given patient will return. In addition, any student or rehabilitation worker needs to develop a thorough understanding of the psychologic meaning of work in our culture. A third prerequisite is a sufficient knowledge of psychiatry, sociology, and psychology to enable one to assist others in helping the patient to establish reasonable and meaningful social, vocational, and economic goals and to work with the patient toward attainment of such goals.

There are numerous opportunities for occupational therapy to contribute to rehabilitation programs. The nature of occupational therapy and the therapist's understanding of the psychologic significance of action and objects provide a means for obtaining evaluation of the patient's skill and difficulties in relating to and sharing with both peer groups and authority. Evaluation and assessment of the patient's integrative capacities, organizational ability, capacity for abstract or concrete thinking, manual dexterity, skills, etc., are also possible and represent only a few of the areas of patient functioning that can be assessed (see "Outline For Evaluation," p. 104).

Those aspects of programming within the hospital that occupational therapy can provide are

1. Opportunities for patients to have meaningful contacts with persons and groups in the community and from the community, such as work with volunteers, patient participation in organizations outside the hospital (membership in and attendance at club meetings in the community), and

patient attendance at and participation in community events.

2. Development of acceptable work habits, work tolerance, and practice of skill.

3. Opportunities for reality-testing situations, such as exploration of the patient's ability to use initiative, to perceive, accept, and act on responsibility, and to explore and experiment in regard to relating to authority and to developing a sharing, collaborative working relationship with peers.

4. Opportunities to test the capacity to accept instruction, criticism, failure, and success.

5. Opportunities for the patient to become aware of both his assets and his limitations and to learn to function within them.

6. Development of avocational interests that may facilitate social relationships and provide ego support.

7. Refinement of social skills through opportunities to become aware of social techniques and customs and to practice these skills.

Such experiences are available in most occupational therapy situations and are also possible in a variety of job placements within the hospital. Utilization of various hospital maintenance jobs and services for patient treatment and rehabilitation has been a common practice in psychiatry for many years. Unfortunately, in some instances the job or service to be accomplished was placed above the patient's needs, and hence this form of patient programming came into disrepute. The placement of a patient in a job within the hospital has many values and can be discredited only when the assignment is made indiscriminately or determined primarily by the needs of the hospital. It is wrong to believe that because in some instances patients have been ex-

ploited for the benefit of the hospital, the use of hospital work programs is contraindicated in a progressive treatment program. The therapeutic and rehabilitative value of a hospital job assignment depends on the purpose of the assignment and the manner in which it is used by both patient and staff.

Occupational therapy is only beginning to explore possible roles and functions in rehabilitation programs outside the hospital. Certainly with the increased numbers of ambulatory patients because of the concerted efforts on the part of psychiatrists to keep patients out of hospitals, there is an obvious and ever-increasing need to explore and evaluate objectively the potential of occupational therapy in such areas as the sheltered workshop, day hospitals, community centers, outpatient centers, or halfway houses.

Correlation is high between the success of any rehabilitation program and the treatment program and culture or milieu of the hospital. The success of rehabilitation is so dependent on the structure and therapeutic philosophy of the institution that in outstanding programs one is readily able to discern that methods and concepts of rehabilitation and therapeutic milieu are mutually dependent and intermeshed. Dr. Brooks's [2] interest and concerted efforts in developing a therapeutic milieu in which rehabilitation of his patients was possible provide an outstanding example. At Massachusetts Mental Health Center a work program developed out of a pilot program of a therapeutic community. In still another program, one of the first work assignments for the chronic schizophrenic male patients was removing the bars of their own windows.

[2] Chittick, Rupert A.; Brooks, George; Irons, Francis; and Deane, William: *The Vermont Story*. Waterbury, Vt.: Vermont State Hospital, 1962.

The publication *Rehabilitation of the Mentally Ill*[3] deals with many facets of rehabilitation programs, presenting a broad spectrum of philosophy and defining both hospital and community aspects of rehabilitation. This book contains much that is of value to the occupational therapist in helping to point out successful areas of functioning as well as those that require re-evaluation.

Most concepts concerning rehabilitation programs emphasize the necessity for cooperative effort within a milieu conducive to shared goals and concepts, inclusion of all personnel working with the patient, as well as helping agencies in the community, in planning and decision making, and a recognition of some values of the "therapeutic community" in rehabilitation efforts. In this respect, it becomes important to avoid placing the patient in an environment that presents inconsistent demands. For example, the patient who is expected to work with responsibility and productivity may return to a ward where the organization and procedures deny or limit his capacity to function responsibly. And with the varieties of persons involved and disciplines represented in most programs, considerable efforts must be expended by the staff in working toward mutually sharing relationships. "Departmentalization" or overspecialization that fragments programs seriously interferes with the patient's struggle to organize and integrate experiences.

George, an 18-year-old boy, was admitted to the hospital because of increasingly severe withdrawal, depression, inability to continue his schooling, fantasies about suicide, and a general all-pervasive diminution in functioning. The patient's father had died when George was two years old, and

[3] Greenblatt, H. Milton, and Simon, Benjamin (eds.): *Rehabilitation of the Mentally Ill: Social and Economic Aspects.* Washington, D.C.: American Association for the Advancement of Science, 1959.

his mother, an overprotective, compulsive, controlling person, did not remarry but "devoted my life to being both a mother and a father to George." The patient was an extremely dependent, inadequate boy with very limited masculine identity. He was markedly ambivalent concerning maternal dependency but totally unable to recognize or deal with his hostility. He had had no opportunities for masculine identification. The only masculine relationship available to him had been with the high school printing teacher, but this was short-lived and terminated when George left school. The significance of this relationship and his infantile needs were exemplified in his vacillations and "halfhearted" thinking about becoming either a nurse or a schoolteacher.

It was felt that an occupational therapy experience should be directed toward working through some of his dependency problems and providing opportunity for masculine identity. Considering both these factors and using the patient's possible identification with the printing teacher, it was suggested that George become involved in printing.

It is not the purpose here to present the course of treatment, but after seven months George's dependency needs had considerably diminished, and he had begun to be able to express anger more appropriately and without profuse anxiety. He was able to work with and for the female occupational therapist, obtaining considerable gratification from this relationship, and at the same time to explore his capacities to function independently. He assumed responsibility for all printing operations, did the layouts for the hospital newspaper, and in the process earned the respect and friendship of the male group members. At this time, the occupational therapist, George's doctor, and the social worker began to work with this patient toward planning for the future. He entered printing school and, before leaving oc-

cupational therapy, taught two of the patients to set type for the newspaper. He has completed his year of schooling with success and has obtained a job through the school.

Mrs. K., a 39-year-old housewife, was admitted during an acute psychotic episode precipitated by the illness of her husband. Mrs. K. is an extremely dependent, infantile woman who has been cared for most of her life by her husband. He has worked at night in order to be at home during the day to do the housework, the laundry, and the cooking. Mr. K.'s hospitalization left his wife completely destitute, and a psychotic episode occurred.

Since her remission, the social service department had worked with Mrs. K. to plan for her return home and the problems of caring for her convalescing husband. However, the patient was panicked at the prospect and obviously needed more concrete help. It was decided at this point that the occupational therapist with whom she had been working would arrange time to take Mrs. K. home on short visits, help her to shop, and teach her the basic skills of housework and of menu planning and simple cooking. This has proved to be a highly successful endeavor. The occupational therapist and social worker have worked together with the patient and her husband, and both these persons are beginning to work together on their problems. The occupational therapist continues to spend some time with Mrs. K. in her home, and the patient has received enough support to be able to assume some of the basic responsibilities of a housewife. The couple has many complex problems for which they will continue to need help, but the patient has been able to leave the hospital early and care for her husband because of the nature of this programming.

One further example of how occupational therapy may function in the rehabilitation program concerns a group of convalescent female patients. In one hospital, patients on the open convalescent ward are expected to seek and obtain employment. Since residence on this ward is by and large contingent on employment, the patients often express feelings of considerable pressure and anxiety about failure to obtain a job, as well as anxiety about their abilities to function once they obtain work. An occupational therapist is generally on the ward when these patients return from job hunting, and since she is available, the patients often talk with her about their concerns. From these more or less impromptu sessions a group has developed and meets regularly to discuss such questions as how to apply for a job, what to do during an interview, what clothing to wear, what to say about being hospitalized, and any other problem that comes up relative to the work situation. New patients arriving on the ward are immediately invited to the sessions, and the group members have been extremely helpful in orienting these new patients by giving them the benefit of their experiences.

ADDITIONAL REFERENCES

MEYER, H. L., and BORGATTA, E. F.: *An Experiment in Mental Patient Rehabilitation*. New York: Russell Sage Foundation, 1959.

PROEHL, ELIZABETH ANNE: "The Transition from Institutional to Social Adjustment," *Am. Sociobiolog. Rev.*, Vol. 3, No. 4, 1938.

"Social Rehabilitation of the Chronic Mental Patient," Project Report, Philadelphia State Hospital, Department of Welfare, Pa., 1959.

SWADOS, HARVEY: "The Myth of the Happy Worker," in *Identity and Anxiety: Survival of the Person in Mass Society*. Glencoe, Ill.: The Free Press, 1960.

CHAPTER 12

Treatment Planning

One professional obligation of the occupational therapist is to assume responsibility for giving an opinion concerning referral of a patient to occupational therapy as well as to suggest what the nature of the occupational therapy experience should be for that patient and what may be expected from such an experience. The responsibility of the psychiatrist is to assess the nature and extent of pathology and determine those areas with which treatment should be primarily concerned. Such expectations require that the occupational therapist be sufficiently involved to have access to the necessary information and work collaboratively, both in planning and in implementation.

Admission conferences provide an excellent opportunity for obtaining data about a patient, observations about how the patient functions during the interview, and an exchange of ideas concerning appropriate treatment goals with other staff members. It should be possible at such a conference, if it occurs early in the patient's hospitalization, to arrive at an agreement concerning general treatment goals and orienta-

tion and to make some decisions about referral of the patient to occupational therapy and what experiences would be of benefit.

If admission conferences do not take place early enough to provide initial information, the occupational therapist must assume responsibility for obtaining what information is available from other sources. Admitting notes are always available, as are the impressions of nurses, aides, and doctors on the ward where the patient is living. In addition, the social service department may well have had some contact with this patient or his family prior to admission. These data, plus one's own interview with the patient and observation of his behavior on the ward, should supply enough material from which tentative plans may be made.

When information from either the admission conference or one's own observations does not seem sufficient for planning, or when specific questions arise concerning the nature and extent of the patient's pathology, occupational therapy can be used for the purpose of providing additional diagnostic data and evaluations, and treatment planning is postponed until adequate material is available.

Once the general plan for treatment has been agreed upon, the occupational therapist must make decisions about the nature of occupational therapy for the patient. Such planning should be specifically concerned with determining the kind of action and relationships that can be expected to exert an appropriate influence on the patient's needs and problems. In such treatment planning for occupational therapy, those questions that need to be considered are

1. *What is the nature of the patient's pathology?* What are the difficulties in thinking, perceiving, and functioning?

What unconscious needs and conflicts seem to be causing problems? (The outline for evaluation, p. 104, will be of help in determining those areas about which one needs to be concerned.)

2. *Which problems are to be of primary concern at this time?*

3. *Is the treatment process to be oriented toward uncovering, support, or repression?*

4. *What are the primary problems in the area of interpersonal relationships?* How may the patient be expected to behave in relation to others? What constitute the nature and quality of a relationship that can be expected to be of benefit at this time?

5. *Which activities can be expected to meet treatment needs and elicit desired responses?*

If the patient is to be in psychotherapy, it is important at this time to discuss thoroughly the occupational therapy plans with the psychotherapist, in order that psychotherapy and occupational therapy may supplement one another and not be in conflict. It is essential that these sessions also occur frequently and regularly while the patient is in occupational therapy.

The first meeting with a patient should take place as soon as plans have begun to be formulated, and this should be arranged so that patient and therapist meet without interruption or distraction from others. It is preferable to meet with some patients in a quiet room on the ward, while others will be more comfortable meeting in the occupational therapy room. The first session should be directed toward getting to know the patient and giving him an opportunity to make some judgments about the occupational therapist. The

patient needs to know who the occupational therapist is, what occupational therapy is about, and why it is important to him. These are questions and problems that must be talked about, and the extent to which they are discussed will depend on the individual patient and his capacity to understand and integrate such information. It has been our impression that even very disturbed, confused, and distractible patients do grasp a sufficient amount for it to be reassuring and helpful to them. In these instances, it may be sufficient simply to state to the patient that he is being referred for treatment to help him get well or help him feel more comfortable. With other, better-integrated patients, it is helpful to explain more about the reasons for referral, such as to "help you with your feelings of depression" or "help with the angry feelings you have."

One of the most difficult tasks for most occupational therapists is to explain occupational therapy to a patient. Here again, there can be no set format, and it is always helpful to know enough about the patient to be able to use this knowledge in the explanation or to make use of the patient's ongoing behavior or activity in the session as an example of how action may help him to feel better and to work through his problems. Thus, if a patient has been reading or watching television, the therapist might talk about how this kind of activity helps relieve anxious or uncomfortable feelings, explaining that this is essentially what occupational therapy is all about, i.e., that when one is upset, tense, depressed, one may read, watch television, take a walk, or work industriously in an effort to lessen such feelings. Occupational therapy means performing certain actions that will help one feel better and, in the process, enable one to better under-

stand oneself. For the more sophisticated patient, a less-generalized approach may be necessary.

This meeting provides an opportunity for the occupational therapist to observe the patient's behavior and response and assess these against information and data previously obtained. It also enables the patient to form some opinions about the occupational therapist and what he perceives the therapist's expectations to be. The patient's feelings may frequently be discerned by a perceptive and observing therapist, and such observations are invaluable in predicting responses and understanding what goes on in future sessions.

The patient needs to be told the time of his future appointments, whether he will be seen in individual or group sessions, and where the sessions will be held. Hesitancy or fears about coming may be talked about, and if necessary, further reassurance may be given by a visit to the area.

Immediately after the interview, it is important to make preparation and plans for the second session. If it has been decided that early involvement in an activity is indicated, it is necessary to select and have ready a few appropriate activities from which the patient may make a final selection. When such decision making for the patient is contraindicated, the therapist should make a selection and be prepared for the patient to begin a specific activity. On the other hand, if treatment plans indicate that engagement in an activity needs to be postponed, one must anticipate what other experiences will be significant and how these might be used for the benefit of the patient. For example, it is helpful to do some thinking about the extent of isolation that will be provided or accepted, the extent of interaction and contact with peers and therapist, and the opportunities to

explore and observe. Thus, plans must include consideration and evaluation of

1. The amount of support, reassurance, dependency, structure, or independent functioning and freedom.
2. The extent to which the patient should be "left alone," i.e., in a quiet corner by himself, included in a small group, introduced to a few or all patients, encouraged to share with others, etc.
3. The kind of activity and how it should be presented, such as the orientation to process, emphasis on performance, on the end product, or on minimizing these.

It is evident that such expectations require that the occupational therapist be thoroughly familiar with the use of the outlines for evaluation and activity analysis. Sound treatment planning can occur and be of benefit to the patient only to the extent of one's knowledge of the dynamics of occupational therapy.

We have selected a few examples of treatment plans for the purpose of further clarifying this process.

Dorothy D. was hospitalized during an acute psychotic episode. She was confused and disorganized and had feelings of depersonalization during which time she mutilated her body.

The patient is a 27-year-old twin whose sister was married and living satisfactorily with her husband and children. The patient had always felt inadequate and unable to compete with her sister, whom she saw as attractive, intelligent, and able to "get people to like her." She felt she her-

self had none of these qualities, was "out of place," and had been "left without love." Dorothy was described by her family as self-conscious, quiet, withdrawn, and inarticulate. She had few acquaintances and spent most of her time at home. Her mother was described as a rather cold, removed woman who tended to become disorganized and overwhelmed rather easily. The father is a stern, judgmental minister who had always been extremely critical of the patient.

After completing high school, Dorothy was upset at not being able to get into college when her sister did. She then entered a nursing school but became extremely anxious, confused, and disorganized and was asked to withdraw. She then entered a school for airline hostesses, was able to complete the training, and worked as an airline hostess for one year. During this time, her mother stated that "she seemed like a different person when she put on that uniform." However, at home she was infantile, demanding, and dependent, becoming more withdrawn and uncommunicative. Ultimately, she was unable to leave the house and go to work and required hospitalization.

This patient had a strong sense of inadequacy and feelings of isolation. She had excessive dependency needs but also much ambivalence and expected immediate rejection. The patient had difficulty verbalizing, was diffuse, and became frightened by her distorted perceptions and confusion.

At the admission conference, it was decided to plan long-term, intensive treatment for this patient directed initially toward gratification of her basic infantile needs and ego support. On the basis of this information and these treatment plans, it was determined that occupational therapy should be directed toward

1. Establishing a dependent relationship in which infantile needs could be gratified.
2. Providing structure and organization sufficient to provide support for the patient and reduce feelings of disorganization and confusion.
3. Providing opportunity for reality testing to help the patient differentiate reality from fantasy and to deal with some of her distortions.
4. Offering experiences of immediate gratification and a sense of accomplishment.

In psychotherapy, it was planned also to explore with the patient her experiences in occupational therapy and her feelings about them.

Activities in occupational therapy were planned to include eating and cooking to gratify infantile oral needs and simple mosaic tile projects or numbered paintings to meet the need for organization and structure and for immediate gratification and a sense of accomplishment. In addition, because of this patient's extensive need for structure and limits at this time, it was planned to work with her to develop a detailed schedule of daily activities so that she would know what was to happen each day and be able to be involved in routine, organized, and structured experiences most of the time. It was further planned to include her ultimately in one of the occupational therapy groups to provide opportunity for her to explore relationships with her peers in a protective setting.

Charles F., a 19-year-old boy, had been hospitalized because of increased hyperactivity and anger that he could no longer control. He complained of feeling "furious," de-

pressed, anxious, and frightened all the time. His mother was described as controlling in a subtle, manipulative way, overprotecting him, and being excessively preoccupied with his health. The patient described her as "overly neat and very well organized." The father is a passive, obsessive-compulsive man, who was completely dominated by his mother and is now dominated by his wife. The only contact the son has had with the father has been on occasions when the mother would purchase tickets to ballgames and "send" the two off to "enjoy a man's day." The patient worked very hard at developing skills in competitive sports and succeeded quite well. However, in spite of his involvement in sports, he never developed any close relationship with his peers and remained totally involved in the process of competition, avoiding opportunities for relationships and interaction with others. Prior to hospitalization, he became panicked about sexual fantasies he was beginning to have while he was engaged in competitive sports.

He always had difficulty in getting along with boys in school, saying that they teased him and called him a mother's boy. On two occasions, one when he was sent to camp and again when he joined a boy scout group, he became panicked and had to leave. At the age of 13, at the time of his bar mitzvah, he experienced severe headaches and stomach cramps, had nightmares, and began having feelings about wanting to kill his mother.

He has had periods of extreme hyperactivity, becoming involved in multiple jobs. These were followed by periods of depression in which he was completely inactive. The patient says he is in constant panic for fear he will lose control.

Treatment for this boy was to be directed toward help-

ing him develop some feelings of control of hostile impulses, providing ego support and increased masculine identity, and toward helping him deal more adequately with some of his feelings about his mother and father.

In keeping with these goals, the occupational therapy program should

1. Provide external structure and a sense of control in structured activities that have well-defined limits and procedure.
2. Provide relationship with a female occupational therapist that will be supportive but enable the patient to experience interaction with a mother figure that is neither manipulative, seductive, or infantilizing.
3. Offer activities that are masculinely oriented but only to the extent of his capacity to function in a masculine way at this time.
4. Avoid overt, hostile, aggressive action because of his fears of loss of control and the sexual significance this seems to have for him.
5. Emphasize the process of doing and his interaction with others rather than an end product or skill, to avoid at this time his getting caught up in his feelings about needing to compete.
6. Select activities that minimize chances of competition. A carving project is suggested with soft wood since it is neither entirely masculine nor feminine—motions are gross but do not involve extensive aggressive acts, and most important, no other patients are engaged in this activity and thus feelings of competition should be minimized.

Ultimately, as the patient experiences a better capacity for control and extreme anxiety is diminished, it may be

possible to explore with him some of the reasons for his difficulties in functioning. If such a decision seems wise, the occupational therapy experiences will be altered to provide freer and less-structured action.

Joanne K., a 20-year-old girl, was seen at admission conference after transfer from another hospital. She had been picked up off the street by the police, who found her wandering around in a state of confusion. She was incoherent, screaming loudly that someone had tried to kill her, and was obviously hallucinating. The patient had been in music school but had left without her parents' knowledge and had been walking the streets picking up a variety of men.

Joanne is an intelligent college student who did well in her studies but who remained aloof from her peers, feeling she never really belonged to any group. She used intellectualism and "individuality" as defenses, and this served to keep most of her peers distant from her. She is an extremely isolated girl who has never really managed to develop any close relationship except with her father.

The father is an accomplished musician who has set extremely high standards for the patient's intellectual and musical accomplishments. She regards her father as a genius and feels hopeless of ever being able to obtain his love and respect because she is "so stupid and ugly." The patient stated that when she "fails her father," he reacts with a violent anger. The mother is an equally gifted artist who has had little interest in the patient and little time to devote to her.

The patient has always seen herself as ugly and unattractive, has felt unloved, and has experienced an overwhelming sense of futility. She stated that she has never experienced a sense of real joy or satisfaction. She believes her parents

can accept her only if she achieves academically or musically; she has been able to achieve in music, but each time success is evident, her feelings of isolation and loneliness become intolerable. She avoids close relationships and is frightened by any warmth or expectation of pleasure.

During the interview, the patient was extremely guarded, attempted to involve staff members in intellectual discussions of music and literature, and was unable to talk about her problems or real feelings. Although she is an attractive girl, she dresses and wears her hair in an extremely unbecoming, plain fashion. She gives the impression of having very tenuous control.

A treatment program was discussed for both psychotherapy and occupational therapy, and it was decided that treatment should be supportive and directed toward improved self-concept and ego gratifications. The tentative plans for occupational therapy were

1. To establish a relationship with her on her own terms, recognizing her need to intellectualize and using this as a means for reaching her.
2. To provide cautious praise for effort rather than accomplishment, indicating that what she does or can do is not one's basis for acceptance.
3. To provide an activity experience in which she can use her intelligence more constructively and as a bridge to relationships.
4. To provide support in and opportunities for obtaining pleasure and gratifying narcissistic needs.

It is planned to place this patient in the hospital newspaper group where she can do creative writing and editing

and thus use her intellectual capacities in a productive way with a group of peers. Individual sessions are to be arranged wherein a close relationship with the female occupational therapist may be established and ultimately used to help her find gratification in learning to use makeup, selecting clothing, and styling her hair. In addition, arrangements are to be made to have this patient work with one of the staff in dance therapy where she may be helped to develop a more appropriate body image and begin to use her body with pleasure and gratification.

John K., a 32-year-old lawyer, was hospitalized because of an extreme sense of worthlessness, feelings of inadequacy, increased withdrawal, inability to continue working, and suicidal thoughts. The patient is married and the father of three small children. His wife stated that he has always been a meticulous, compulsive person who has found it difficult to make decisions on his own. She feels that her husband's illness was precipitated by the death of his father, who had always "ruled John, telling him what to do and how to do it." The father was an ambitious, successful businessman who set high standards for his son, was a stern disciplinarian, and expected compliance. The patient believes he caused his father's fatal heart attack because he refused to enter the family business and feels extremely guilty about this.

The patient was seen in occupational therapy for the purpose of obtaining additional information about the nature of his self-concept, the extent of his hostile feelings, and his capacity to function. The occupational therapy evaluation summary stated: "During the first session, Mr. K. was obviously quite anxious. He was unable to make any decision about beginning an activity and was quite concerned about

this, asking the therapist several times what she would like for him to do. His behavior has been quite passive, he is completely dependent upon the occupational therapist for decisions about what he will do and how this is to be done. He acts upon suggestions as though they are commands and follows through without question.

"Although he sits at a table with the group, there is little interaction with others and he works in a removed isolated fashion responding only with a 'pleasant smile.'

"His activity performance indicates feelings of unworthiness and inadequacy and a fear of disapproval. He is extremely cautious and compulsive and quite sure he will make mistakes, demonstrates no originality and is dependent upon pattern or instruction. He avoids the creative activities and is able to work only with highly structured ones.

"His inability to assert himself or experience anger was evident in his response to one of the aggressive male patients who taunted him in a very provocative manner about his dependency upon the therapist. Mr. K. responded with his typical 'pleasant smile' and apologized to the therapist for the other patient's 'boorish' behavior."

On the basis of these observations the following suggestions were made concerning occupational therapy:

1. At this time provide fairly structured repetitive activity in which decisions are minimized.
2. Activities should contain some elements of resistiveness to help him begin to explore more assertive, aggressive behavior.
3. The relationship with the therapist should provide support, dependency, and reassurance.

4. Mr. K.'s realistic achievements and assets need to be clearly pointed out to him.

5. Provide help and support in teaching the patient that more assertive behavior will not bring disapproval.

6. When appropriate, programming should include increased opportunities for decision making in both individual activity and the group situation.

James L. is a 27-year-old man whose insecurity and sense of inadequacy and anger are repressed by compulsive, perfectionistic behavior, a critical, derogatory attitude toward others, and projection. He is a well-educated music teacher who had increasing difficulties in holding a position because of his inflexibility, perfectionism, and critical attitudes toward others. Although Mr. L. was sufficiently concerned about these problems to seek help, he seems to be almost totally unaware of his real feelings and how these affect his functioning. He has withdrawn more and more from contact with others, stopped working, and sought treatment as an outpatient at the suggestion of a physician friend.

This patient is to be seen in psychotherapy and occupational therapy for the purpose of helping him to become aware of some of his feelings, uncover some of his unconscious conflicts, and work toward increased self-awareness.

The occupational therapy plans are for him to become involved ultimately in creative, expressive activities that will

1. Elicit some of his concerns about masculine identity.

2. Assess the nature and extent of his sense of inadequacy and worthlessness—his "unacceptable" self-concept.

3. Explore the nature of his anger.

However, at this time, his need to control and his obsessive-compulsive needs are such that it will be necessary initially to provide activities that contain these elements. It is planned to use either clay or paint media that involve copying or following a pattern.

REFERENCES

BURTON, ARTHUR (ed.): *Psychotherapy of the Psychosis.* New York: Basic Books, Inc., 1961.

GILL, MERTON, NEWMAN, RICHARD, and REDLICH, FREDERICK: *The Initial Interview in Psychiatric Practice.* New York: International Universities Press, Inc., 1954.

SHAPIRO, DAVID: "Aspects of Obsessive Compulsive Style," *Psychiatry,* Vol. 25, No. 1, 1962.

VON MERING, OTTO: "Activity Therapy Planning and Hospital Life Experience," Procedure of Workshop Conference of Activity Supervisors, Pennsylvania Department of Welfare, June, 1958.

WHITEHORN, JOHN C.: "Emotional Responsiveness in Clinical Interview," *Am. J. Psychiat.,* Vol. 94, No. 2, 1937.

CHAPTER 13

Current Practice

The translation of concepts and principles into practice is likely to present a problem in any field. In most instances one feels there is a gap between theory and practice. Some illustrations of current practice that approximate our objectives may help to demonstrate these as well as point up both the assets and the limitations of our concepts and principles. We have therefore chosen some groups and individuals in treatment with occupational therapy as illustrations presenting a variety of problems, goals, and techniques.

GROUP PROCESS 1

An occupational therapy staff became aware that their programming provided no task-oriented activity group experience for patients. They saw such a project as an opportunity to meet patient needs for cooperative effort and to expand their own skill and knowledge.

Discussion with patients concerning their interests ultimately led to a decision to organize a group around the pub-

lication of a newspaper. It was anticipated that the tasks involved and the cooperative efforts necessary in publishing a paper would provide opportunity to meet individual treatment needs and provide experiences in which patients could more readily see the influence of their feelings and behavior on relationships with others.

The following are excerpts from notes kept on the group meetings by the occupational therapist. These notes cover some aspects of the first six weeks of meetings, which were held twice a week. The six members of a group of eight who were most significantly involved in the incidents here reported were the following:

Neil, a 26-year-old, suspicious, controlling authoritarian who sets extremely high standards for himself and others. Has little understanding of his problems and uses rationalization and projection in a hostile, defensive manner. He has been hospitalized for one year after a paranoid episode in which he threatened his supervisor. Had been an executive in a boys' organization but was asked to leave because of his inability to work cooperatively with others. In psychotherapy he has remained suspicious, guarded, and evasive.

Margaret, a 22-year-old, extremely withdrawn, insecure, indecisive, autistic girl who is in remission from a severe psychotic episode with regressive behavior. She has a great deal of difficulty in expressing her feelings, is inarticulate, and still fairly confused and disorganized.

Carl, a 19-year-old bright boy who was hospitalized because of totally disabling compulsions. All decisions are extremely difficult for him, and most are impossible. He has a great deal of difficulty verbalizing, and uses denial, rationalization, and intellectualism as a defense. He has developed a good relationship with his psychotherapist and in these

sessions has become much less restricted. However, in other situations he is indecisive and compulsive to the extent that he has remained essentially uninvolved and noncontributing.

Joanne, a 20-year-old recent admission who is an aloof, self-deprecating girl with good intellect and ability but whose concept of herself as ugly and unacceptable makes it difficult for her to function and relate to others. She uses intellectualism in a hostile, rejecting way and was hospitalized after repeated involvement with the police because of sexual acting out.

George, a 26-year-old, hostile, attacking person who finds it difficult to control his anger. He strikes out with sarcasm, is critical, and tends to circumstantiality, particularly when he feels threatened. Has been previously hospitalized for attacks against his wife. During the past year in the hospital, he has been very uncooperative, threatens anyone whom he feels is pressuring or coercing him. He feels extremely inadequate and rejected and reacts with violent rage.

Jim, a 35-year-old married man, recovering from a severe depression during which he attempted suicide. He is capable and intelligent but sees himself as a failure and has many doubts about "being a man." He avoids contact with others and is afraid to become involved in any activity.

First Meeting. An enthusiastic beginning, although somewhat confused; began by patients' making veiled attacks on the hospital; much talk about writing critical articles about doctors and the hospital. Group began fantasizing about doctors; I asked about other ideas; came back to discussion of the purpose of a paper, what it should contain. Many ideas were voiced by Neil, who tried to run the meeting. George made several angry remarks and left. Margaret very quiet

and anxious-looking. Seemed taken aback by such vigorous discussion. Carl talking about the need for it to be on a good intellectual level. Joanne saying, "Who's intellectual?" Jim taking leadership role occasionally but pulling back each time. Neil attempting to keep others on the track and get things going and organized. Group raised questions about how to get things started—I suggested this be thought about and talked over at the next meeting. Adjourned with much discussion continuing as they left.

Second Meeting. A remarkably constructive and active planning session. Group elected Neil as chairman. Neil quite organized but very authoritarian in getting others lined up for various jobs. Several members suggesting others who could write articles; made list of "departments" and talked about who might take responsibility for each area; again talk about writing "attacking articles about hospital." Joanne picking this up and ad libbing an editorial in a very hostile manner—George laughing in an anxious, loud manner. I feel they may be asking about how much freedom they will have —will I censor, etc. Must bring this up next time.

Third Meeting. Action slower today. Talked more about who would take responsibility for what; many questions about who could do various jobs; much hesitancy about committing themselves. Neil pressing. Carl quiet today with Joanne urging him to take poetry editorship. Jim urged group to come to some decisions. Finally able to agree on assignments and each member accepted responsibility, agreed to do some work by the time of the next meeting. I feel they need much help from me in getting started. Perhaps I should be more active and structure the situation more.

Fourth Meeting. A letdown today—entire group subdued. Neil arrived late, somewhat disorganized and acting angry.

Jim very quiet and abruptly left early. Neil did not call the group together. I mentioned "lack of enthusiasm." Group did not pick this up. Neil then tried to get things going; the group was silent, unable to get started. Neil left early; others left; Carl, Margaret, and Joanne stayed, talked about feeling "low." Carl suggested this had to do with being afraid of responsibility, of having to get started. I suggested this be brought up at the next meeting. I believe the group are afraid of responsibility and of doing and are getting quite anxious. I am concerned that Neil is also afraid and cannot handle this fear or the group.

Fifth Meeting. Neil more organized today. Called meeting to order and began going over the list of things that needed to be done; reviewed first two sessions relating to plans. Group responded well and began rehashing what should be in a newspaper. I interrupted this, asking what they thought was going on. Silence. Then I interpreted very directly both what I felt to be the fears of the group about producing and also their need to "tone down any expression of hostility." Made everyone quite anxious; much angry denial on their part. Neil fairly quiet; George very angry. Tension rose considerably. Felt I had to bring up these issues yet was aware I had "pushed into the group." Entire group left early and quite frustrated!

Sixth Meeting. Group arrived late, left early. Much "joking" about hostility—a fairly uncomfortable atmosphere but no real discussion about what is going on. Meeting disorganized. George getting "high" again and Neil having difficulty keeping him in order. General talking among rest of group about what they had not done. Neil apologized with a great deal of sarcasm for not having written anything. Not reacted to by the group. Margaret asked a question with much

difficulty. Joanne walked out. I asked "What's going on here?" Carl picked this up with much explaining and rationalizing; Jim talked about lack of enthusiasm in a defensive manner; George suggested next meeting be canceled; Neil shouted, "No, there's work to do." Carl back again with feelings of really being frightened about having to produce, then remarked that I was a therapist not an editor. George exploded, saying, "Well, I'll be damned if she'll treat me—this is not group therapy." Group seemed to agree with him and left, Neil looked angry and confused. I really feel now that the group is frightened about expectations of producing.

Seminar discussion of group also pointed up another problem of which I was unaware, a covert problem of Neil and me in struggle for group leadership. We have different goals, I have to work through him in order to get to the group. Suggestions that I talk to him about the problems of the group, give him support; also that I must go slower, am interpreting too directly. It all makes sense—just wish I were wiser and not so anxious.

Met with Neil. His distrust, hostility, and resentment toward me as both woman and authority sifting out through polite "front." Very little awareness of what is happening in group except his sense of frustration about the others' not being able to "fall into line with what is expected from a working group." Feels they must be "whipped" into action; very suspicious of me and my motives. Apologized for any sarcastic remarks he might have made to me and began talking about feelings of pressure—tremendous expectations for himself but very pessimistic about being able to "carry through." Then became more guarded again. I offered him

an hour a week to talk together about the group. He accepted but obviously has misgivings.

Seventh Meeting. Neil arrived early and a bit uneasy about the meeting. Margaret and Jim arrived on time; rest did not appear. Neil quite put out at this and went to get them. Reappeared with group who had assembled in the coffee shop and were having their own meeting. Neil angry but reasonably well controlled. Remarked that everyone seemed to have a case of "avoiditis" and asked for a rundown of what they had done. George off in a corner drawing and playing with typewriter. Margaret uncomfortable about not having written much—presented a rather confused article. Joanne criticized this in a cold way; Carl supported Margaret. Group begins to come together; Carl seemingly pleased with his ability to support Margaret; suggested that Neil is being too hard on the group. Neil accepted this and apologized. (Did my session with him really help?) Neil adjourned meeting. Seemed to want to stay afterward but left with group. I feel much better relaxing and letting the group work things out —I really jumped in much too fast; it will take a while. Feel encouraged about Neil's functioning today; feel more supportive of him and less threatened by him. Neil came in next day and brought me wooden blocks that I had needed for mimeograph machine.

Eighth Meeting. Meeting a good one, both from point of getting material in and of expressing feelings and attitudes related to this with relative comfort—a relaxed and working atmosphere. Neil arrived early with some anxiety for fear group would be late again. Group assembled without comment about their lateness. This was deadline day they had set for their articles. Discussion of material that had come

in—Joanne read article; very well written and group most enthusiastic about it and supportive of her. Carl with some apology read his article on housing; good acceptance from the group; commended him on the good research. Group digressed to discuss some problems of housing. Carl obviously pleased at his accomplishment; Margaret presented redraft—is more structured and more organized but still pretty "sick" writing—seemed to want to reach the group. Group quite supportive of her and made good comments —not as embarrassed by her as they used to be. George commented, "Good job, Margaret"—first civil remark he has made. Margaret smiled with warmth. Neil read poem about "incurable" patient; group quite moved by this. George pulled his chair more into the group; Carl raised question about people's feelings of futility, fears, etc. Talked a great deal for Carl. Neil then spoke directly on his feelings of overwhelming responsibilities as chairman, his fear of "cracking the whip" to get things done, his intolerance of anything less than perfection. Group then discussed together their session in coffee shop—how Neil's angry authoritarian handling of them made it difficult for them to function. They feel he takes their hesitancy too personally. They have problems just as he does. Neil talked about wanting to succeed in this job and about his fears of "ruining" the group because of his usual way of acting. I entered the discussion "gently" at this point, restating what had been said. Meeting ended with talk getting back to "where from here?" regarding the newspaper. Things seem to be going well—am so pleased with Margaret's better-organized effort but mostly with her response in reaching out to the group and their ability to accept her now. Also Carl seems to be over a hump now that he has made the decision, "taken the plunge," and done

something. Neil is really trying—will need much support. Is becoming aware of his real sense of inadequacy.

Seminar discussion— The question of why Neil is so fearful of losing his leadership; his sense of inadequacy and need for my continuing to support him in my sessions with him.

Meeting with Neil. He forgot the time. Wondered if Jim could meet with us. Talked about newspaper and his disappointment with the group's poor participation and quality of articles. We talked a little bit about his unrealistically high expectations and his feeling that it is all on his shoulders and that the group cannot really produce. I feel this is a reflection of his feelings about himself but did not make this observation to him—he is not seeing this yet. He is very fearful now that the issue is nearing completion—seemed very depressed. I reassured him that things were going well —called his attention to the last meeting and how well he had handled that. He seemed to feel better as he left.

Ninth Meeting. Active group discussion about articles turned in. Carl quite talkative and more assertive; George offered to do the mimeographing and Neil picked up this gesture and responded with acceptance. Neil not pushing —seemed tense but well in control. Margaret spontaneously volunteered to do typing, and Joanne said she would help and do editing for her. Good activity for Margaret—should help her to feel a little more organized and an active part of group. Group very busy working on final details in preparation for assembling. Carl challenged Neil on a decision—won his point.

Tenth Meeting. Members came in early and began immediately to work on individual jobs—typing, mimeographing, etc. Neil busy editing his own poetry; Carl finally asked

him to call group together. Began talking about final layout and what more material is needed. As meeting progressed, group became more active in discussion. Carl presented another article that had not been included in plans —fairly assertive. Carl and Jim disagreed with Neil about an article. Neil became quite angry—accused Carl of "taking over." Carl pointed up his [Carl's] achievement in his article, cited data to substantiate position. I feel Carl's accomplishment has really meant a great deal to him. Margaret actively, coherently offered support of Neil. Neil's anger increased and he left group. Carl obviously upset but handled it quite well. I point up the pressure Neil is feeling but also attempt to support Carl in his increased assertion—do not know if it helped much.

Seminar discussion—Neil is getting more anxious and angry as the group members develop as more active participants. In challenging his leadership, they are challenging his masculinity—especially Carl, who is emerging as a potential rival for the group leadership. Neil will need increased support.

Supportive Session with Neil. He is puzzled at people's defying him—hurt and angry. Any individual assertiveness he sees as an angry threat toward him. Feels Carl is really threatening him. I attempted to point up to him that the fact that others in the group were able to begin to assert themselves was an indication of good leadership and that they were not attacking him. Told him he was successful and suggested that his feelings now were understandably increased because of his concern to have the group produce a good issue. He seemed reassured and said the sessions were a help to him.

Eleventh Meeting. A "work" meeting with Neil unhappy

over delays but functioning well; Carl and Joanne quite verbal and assertive and able to work constructively. Decision still a problem for Carl but each time it is a little easier for him—still rather anxious. He and Joanne mutually supportive. She is really "coming out." Margaret more coherent than ever—good job on her final work—terribly pleased—is anxious for the issue so she can "show others what I have done." Jim finally able to do collating. Neil talked to the group about his apprehension; seemed to reach out a bit to Carl but still very suspicious of him. Carl feeling the pressure but is verbalizing it more. Neil still looking depressed. Issue gone to press—guess I am relieved also—group is really holding together. I plan to see Neil after issue is out today and commend him.

Saw Neil—seemed depressed. Felt it was not as good as it should have been. Told him it was a very good issue. He blamed himself; I reassured him.

Twenty-third Meeting. Neil spoke to group about his anticipated entry into school in two weeks—brought up the need for a new chairman. Group talked about this; seemed to feel Carl was logical person. Carl had many doubts about this. Neil stated that he was not leaving the group; might be able to attend some meetings; said he would like to continue writing. George said he felt that this was a good idea. George has not "stalked" out of the meeting in weeks—working very hard as "mimeographer." Several new members in group. Joanne suggested Carl try job. Carl suggested a rotating leadership. Group discussed this. Joanne voiced misgivings about her ability—was reassured by George, who said, "I'll goof it for sure." George talked about helping leader plan an agenda, etc. Margaret told group she could not do it. Group reassured her—said she could. She was pleased

and agreed to try. Group finally decided on rotating leadership with Carl taking the first meeting. Carl agreed and followed through on several decisions with regard to next week. Asked a question of Neil. I am not sure the rotating leadership will work, but it should be tried. Is it still their hesitancy to accept responsibility? But then the group has come a long way. Feel Neil still wants to hold on to the leadership. Did he hope group would regret his leaving?

In summary at this point in treatment, Neil has received gratification from functioning as group leader and from the support and acceptance of the therapist. He has benefited from the experience of being able with reasonable success to deal with a working group and not be destructively attacked, to see himself in a working situation and to learn that he did not need to completely control others in order to prevent them from destroying him or threatening his masculinity. These activity experiences have enabled him to sublimate some of his needs to control and for organization and predictability and have provided him with masculine identification. He has been able to leave the hospital during the day and re-enter school to follow through on his interest in law.

Margaret. The nature of her assignments, the organization that was necessary, and working to communicate an idea to others in a way they could understand helped her to test her perceptions and her communication skills. Commendation and acceptance from the group provided ego support and gratification of her needs for acceptance and understanding. Her job of typing provided the structure, organization, and predictability she required at this time.

Carl. The nature of this experience—the task of following through in an activity situation which had structure and

limits and which provided constructive channels for his intellectualism—provided him with one successful completed act. Neil and his behavior toward and relationship with the group gave Carl an opportunity to learn that aggressive feelings and actions do not destroy but can be used constructively. Carl's developing leadership in this group is a manifestation of his growth.

Joanne. Involvement in these tasks provided her with an opportunity to use her critical, evaluative way of looking at herself and others constructively in editing and analyzing material. It further provided an experience of sharing with others in a successful endeavor rather than a destructive one and of seeing others respond positively to her more constructive behavior. Her growing concern about styling her hair and wearing attractive clothing to meetings is an indication of her ego growth.

George. The value of this group to George was his experience in a task-oriented group where he could actually see that others had problems similar to his and that it was safe to express these in action and words because authority did not respond with anger or rejection and because he was part of a group involved in a "worthwhile" task. He received sufficient ego gratification and support to take on the job of mimeographing, which had very obvious and concrete results and was essential to task fulfillment. His identification with this activity gave him a role identification of contributor and essential member.

Jim continues to remain a somewhat silent and removed member but is beginning to interact more. His involvement in assembling and collating the issue was a major step for him in terms of action. The activity seemed to be a symbolic act of putting things together, putting the pieces into a

whole, which meets his need to experience a sense of accomplishment.

GROUP PROCESS 2

Six female patients had been meeting with an occupational therapist four times each week. The group was begun as an experiment in an attempt to involve these patients more actively in interaction with one another and to increase their feelings of group cohesiveness and identity within the ward. The majority of patients from this ward had been in the occupational therapy program for some time, but these girls seemed the nucleus of a small group who remained negativistic about and uninvolved in patient meetings, patient government, and other group activities. All these patients had been in the hospital approximately one year and ranged in age from 18 to 23 years. These attitudes were also evident in their individual functioning in occupational therapy. Admission to this group had been on a voluntary basis to the extent that a girl could choose to remain in her present occupational therapy program or join the group. Prior to forming the group, the occupational therapist had spent one month on the ward getting to know the patients and giving the patients an opportunity to know her. Group membership at this time consisted of the following:

Betty, an articulate, aggressive person who uses intellectualization, cutting sarcasm, and a hostile, superior veneer to hide her feelings of inadequacy, ugliness, and a sense of rejection. Most other patients fear her biting tongue but also have a respect for her courage to "tell off authority" and rely on her to act as their spokesman. She is constantly

pointing out the inadequacies of the occupational therapist and defies any attempt to involve her in an activity or in a positive way with the group. When she is complimented by the occupational therapist on her leadership qualities, she retorts with "Don't be so obvious." The group tends to follow her lead, and she ridicules any of the group if she perceives they are "giving in to the occupational therapist."

Vera, withdrawn, fearful, with poor self-esteem. She needs to feel accepted, wants to relate but is frightened by any suggestion of hostility or any attempt to get close to her. She cannot tolerate being physically close to the group and has been painting at an easel in a corner of the room. She has always felt different from others, extremely lonely and unwanted. She seems to be quite frightened of Betty but quite unable to say "no" to her.

Carie, paranoid, extremely suspicious, hostile, negative. Feels that people are manipulative, has many homosexual fears. She sees most of the interaction of the group as having the covert purpose of manipulating her. She interprets others' behavior as accusatory and derogatory of her, tends to avoid others but is drawn into the group in an effort to defend herself against what she perceives as attacks on her. For example, when Betty remarked that she was not impressed with the occupational therapist's knowledge of sewing and questioned whether she was trained for the job, Carie verbally attacked the group saying she knew what they meant. Why did they not come right out and say it in the open—"I'm as good as any one of you —— fools."

June, an obsessive-compulsive individual who needs to feel there are structure and control. She is indecisive and constantly concerned about doing the right thing. She needs everyone's approval and reassurance and is in a constant

turmoil and state of anxiety about needing to please authority but also needing to please and comply with the group. She finds Betty very threatening and attempts to placate her. Betty finds this attitude most contemptible.

Arlene, an infantile, insecure, overly dependent, and indecisive girl. She needs to placate the mother figure in order to be accepted by her and maintain the dependency relationship. She uses her dependency as a means of manipulating and controlling others. She perceives group members as competitive siblings, is fearful of them, and seems to be completely overwhelmed by what is going on.

Linda, a hyperactive, suspicious, hostile girl who tends to be disorganized easily, is diffuse and circumstantial. She makes attempts to relate to others but such attempts are awkward, usually inappropriate, and elicit anger and rejection from others. Such reactions toward her increase her hyperactivity, her touching of others, and her loud, somewhat incoherent, ramblings.

The ward administrator and occupational therapist had met several times to discuss the formation of this group and make some tentative plans about meaningful activity experiences for them. It was felt that a group activity project that contributed to ward living and comfort would more readily help the patients to relate to each other, increase their self-esteem, and produce a sense of being a vital part of the ward. Thus it was suggested that the group make draperies for the ward dining room since they had been complaining bitterly about the unattractiveness of this area. It was expected that the group would then go on to plan the redecoration of other parts of the ward.

These ideas were presented to the group, and it was sug-

gested that they begin to think about how this might be accomplished. For three weeks the group meetings consisted primarily of angry refusal to become involved in any way with work for the hospital. The patients' attitude had been one of hostility, negativism, and destructive criticism. Betty was the spokesman of the group and encouraged others toward hostile rejection of the entire idea. The group's anger was directed toward the occupational therapist, and they accused her of being dictatorial, authoritarian, and controlling. Vera became more withdrawn and acutely anxious and Carie, more suspicious and projecting. Arlene made numerous attempts to "go along with" the occupational therapist's suggestions but became unable to really follow through on this.

The occupational therapist suggested that perhaps each of their meetings might have a different focus, i.e., one day devoted to working on the draperies, the following two to planning and taking a trip, and the fourth session to working on individual projects for their own use. The group was less negativistic about these ideas, agreeing to try each of them except making the draperies. They talked a great deal about wanting only to spend their time making things for themselves. Individual projects were selected and begun. The patients made most unreasonable demands on the occupational therapist for attention and assistance, and Betty led them in verbalizing their contempt for her inadequacies and inability to function. A cooking session was arranged, and the girls did manage to bake a cake but were vehement in not wanting to do any more cooking. A trip was planned and the planning sessions were "stormy," although the group was finally able to make specific arrangements. On the day of the trip, Vera and June refused to go, Betty left the group and returned to the hospital soon after they left the grounds,

and Linda constantly attempted to run away. Both Carie and June responded in a more positive manner, and they seemed to derive some satisfaction from this experience. However, these attempts could not be viewed as successful, and it was evident that the occupational therapist had to take some definite steps toward dealing with what was going on within the group.

Linda was removed from the group, and arrangements were made for the occupational therapist to see her in individual sessions for a time. The occupational therapist sought out Betty and talked with her about her leadership role in the group. It was pointed out to her that she was the leader of the group and that others looked to her for guidance. The occupational therapist actively solicited her help in doing something about the group situation and asked if she would think about what might help and bring her suggestions to the next meeting for discussion.

At the next session, the occupational therapist told the group that she felt many of their difficulties and feelings were justifiable and understandable and that these meetings had been structured and planned without eliciting their ideas or what they might want to do and that this was an error that needed to be corrected. The group was told that Betty had been asked to think about this and had been asked to bring her suggestions to the group.

Betty talked at length about her and the group's anger and "being led around by the nose" and their resentment at being told to do things that would "make Dr. —— and Miss —— look good." She emphasized that the girls wanted to do what they wanted to do. The group was reassured that they could do what they wanted in terms of activities, and the group agreed to begin by doing only individual projects

for themselves. When some of their former difficulties in functioning within this structure were raised, the group, with Betty leading the discussion, was able to talk about some of their feelings and the reasons for behaving as they did.

Over a period of weeks, the sessions improved considerably. Betty continued to be somewhat hostile and attacking but was obviously responding to the occupational therapist's and group's acceptance of her leadership. She received much ego support and gratification from the responsibilities the therapist had given her of keeping records of inventory and supplies and monthly reports, as well as functioning as recorder for the group sessions. Vera remained primarily in her corner but seemed less frightened and anxious and began to sit at the end of the table for coffee. Carie was able to become involved in planning and organizing a very intricate tile project, which met her need for structure, organization, and predictability and elicited honest commendations from the others. June's numbered painting project provided her with the sense of structure and control she required and allayed her anxieties about decision making. The content of the picture elicited several accepting remarks from Betty, which reduced June's feelings of threat from her. Arlene continued to behave in an infantile, dependent manner, but with the reduced anger and tension within the group, the occupational therapist was able to meet some of Arlene's needs, and she had less need to relate competitively to the others.

Five months after its formation, the group made draperies for the dining room and the dormitory with a great deal of satisfaction. They planned and followed through successfully trips outside the hospital. They ultimately suggested

that each meeting be planned around a different kind of experience so that their "schedule" at this time provides for one day to work on ward decoration, one day for cooking, one day for individual projects, and one day to plan or take a trip. The group has developed a capacity to work and plan together, and they have been able to talk about their feelings and needs as they relate to these experiences with increasing ease. Linda has returned to the group, and both she and the group are better able to deal with one another. The group has also been able to accept two additional members and they have all become contributing members in the patient ward organization.

GROUP PROCESS 3

A group of 10 male patients had been coming to occupational therapy for some time. Six of these patients had worked with a previous therapist, and four were new admissions who had come into the program within the last three weeks after the present therapist had taken over the group. Each patient had been involved in his own particular activity or inactivity, and interaction among them was minimal. We will give some information about each patient and then attempt to show how activities and events were used to bring about increased interaction and group cohesiveness. All these patients were also in individual psychotherapy.

John B., a 22-year-old, angry, silent person who uses activity in a compulsive, pressured manner, needs to keep busy all the time, and uses this to ward off contacts with him. Has many dependency needs, which he denies angrily. Has been coming to occupational therapy for several months.

during his year of hospitalization and has made numerous billfolds in rapid succession.

Mike J., a 26-year-old, cautious, unsure person who is quite preoccupied with intricate detail and works industriously but in a constricted, obsessive fashion. He is very unsure of himself and unable to commit himself in any way other than to follow the meticulous mosaic design patterns. Is one of the original patients and has been hospitalized for three years.

Ken H., a 31-year-old, new patient who behaves in a very rude, hostile manner to the therapist. Has rejected all of the therapist's suggestions of activity and remains aloof from the others, drawing caricatures of the therapist and doctors and accompanying these with sarcastic, provocative comments. He has encouraged Mel's mischievous acting out. Has also been most defiant about the new hospital rule prohibiting smoking in the occupational therapy rooms—smokes and passes out cigarettes to others.

Ernest C., 21 years old, very insecure, somewhat disorganized and confused. He finds it difficult to follow through on any activity requiring more than a few simple steps. Is quite removed and seems to be ruminating most of the time. Attention span very limited. Has been in the hospital for two years for a catatonic episode.

Frank N., a 22-year-old, recent admission who is very unsure of himself and apprehensive. He needs much direction and is very dependent, being unable to move on to the next step without checking with the therapist. Is involved in a tile project with concrete design and specific directions but still requires support in order to act. Remains removed and aloof from others.

Bob T., a 25-year-old, hesitant, fearful person who has been having a great deal of difficulty finishing his wooden bookends. Has sanded them interminably and seems to be quite apprehensive about completing the project and has refused to discuss his second one. Says he does not really want to do anything else.

Pat C., a 35-year-old, new patient who attempts to deny feelings of dependency and inadequacy with an air of bravado—tends to become overactive and loud and makes many "noisy" contacts with others. Has many ideas on which he is unable to follow through. Tends to be somewhat grandiose and is constantly thinking up projects for others to do and offering advice to everyone. Has good skill in woodworking but has been too "high" to use this. Has had two previous hospitalizations because of extreme hyperactivity.

Mack C., a 23-year-old, quiet, withdrawn person—needs structure and a sense of control. Seems to be responsive to Pat's interest in his project but also frightened by his brusqueness. Is involved with tracing a pattern on wood for a hobbyhorse for his young son. Is easily distracted. Is in remission from an acute schizophrenic psychosis and has been in this group for five months.

Mel J., a 24-year-old, very frightened person who panics at the anticipation of any "doing"—producing is very directly related to his hostile feelings about and relationship with his father. He avoids committing himself in any way; indulges in mischievous, hostile acting out. Will accept Ken's cigarettes and light them in a teasing, provocative manner. Has also hidden the therapist's keys on two occasions. He brings a radio to sessions and sits off in a corner playing it loudly. Has been coming to occupational therapy for a long time and has consistently refused to do anything. Previously

hospitalized for five months, discharged, and readmitted a year ago with no appreciable change in his behavior up to this time.

Don G., a 23-year-old, new patient who has been sitting off in a corner drawing. He has not interacted with the therapist or any of the patients. Is made extremely anxious by contact with peers; has a great deal of fear about homosexual attacks, is suspicious and paranoid.

First Meeting. Mack has been trying very hard to follow through on his hobbyhorse but has been having some difficulty with the sawing. Pat approached him and offered to help, taking the wood from him and working on it. Pat then began to make numerous suggestions for changes, and Mack looked confused and hesitant and began to move away. The occupational therapist approached the two, pointed out that it is Mack's project and his plans are good; that it will be successful if he follows his original intent; that Pat is a skilled woodworker and could be very helpful in assisting with technique so long as he does not "take over" Mack's project. Ken, who had been observing this exchange from across the room, shouted, "That's it, Florence Nightingale. Just you tell everyone what to do. Nobody think for themselves around here!" Pat picked this up and accused the occupational therapist of always inhibiting him, refusing to let him do what he wants. The occupational therapist remarked that Ken seemed to be really bothered by the smoking regulations, and perhaps it would help if they talked about this and some of the other restrictions the group seemed to be feeling. Mel joined the discussion with the statement that the greatest restriction was having to come to occupational therapy in the first place; Mack disagreed

with him. Said occupational therapy is good for patients. There ensued a discussion of what occupational therapy is and arguments about whether it really does help to "keep busy." John B. moved in toward the group and attempted to say something about this but failed and returned to his billfold. Discussion was quite active for a few minutes, and the "fringe" patients were listening. Ken then walked away from the group and went back to reading his newspaper. Mack returned to his horse with Pat hovering around him. The occupational therapist observed that perhaps it helps to talk about these things, as well as express them in other ways.

Second Meeting. Pat came in early—brought in hastily sketched plans for improvement on hobbyhorse Mack is making. Occupational therapist pointed out some of the unrealistic aspects of the plans, suggested some alterations. Pat left his sketches on the table and went out to smoke. Rest of the group arrived. Pat returned and began to talk to Mack about his ideas. Mack made some mild comment about some of the ideas' not working and make alternative suggestions. Pat left and approached Ken. They talked briefly. Other patients were working silently and individually, except Mel who was reading the newspaper with his feet propped up on the table. Pat suggested that since Ken is the "artist," he draw the plans for the horse; Ken laughed in a sarcastic manner and told him to get "Florence Nightingale" to help him. Pat gave him a sermon about being lazy; told him that he is just afraid to do anything. Ken retorted that in fact that is Pat's problem. Much argument about this for a while. Mack came over and offered to trace a pattern for Pat. Ken restated to him that Pat wants a different kind of pattern. The two began arguing about how the pattern should be made—Ken began to sketch. Much noisy

argument between them. Mel brought his pattern over for them to use. There was quite a bit of confusion about what they were doing and how to do it. Pat had difficulty being realistic, and Ken told him to shut up but in a less hostile manner than was his custom. They asked Bob T. about wood that can be used, and he offered to help them get some. Became involved in ongoing discussion about how they should proceed. Pat continued to give directions—called again to Mack, who went over to them. [The occupational therapist was aware of their difficulty in getting organized but felt that any movement toward help from her would be unwise at this time.]

Pat getting "high," beginning to talk about a regular assembly line for making numerous hobbyhorses for sale—plans to involve everyone. Made pointed remarks about participation of inactive, "lazy" patients. The occupational therapist felt that this needed to be interrupted—remarked that it is important for each individual to set his own pace as well as make his own decisions about what he does. Ken picked this up immediately and said, "Do what *you* want, that is—that's where it ended last time." The occupational therapist replied that this had not been her observation. Pat supported her with, "That's right." Ken said, "So where did it get us?" Pat attempted to recap the previous day. There was again some talk about "being in a prison," "not being able to 'relax,'" "not even have a cup of coffee or cigarette." Pat suggested that they all go to the coffee shop. The occupational therapist suggested that perhaps two of them could go and get coffee for the group. Pat agreed to do this and talked Ken into helping him. Coffee was brought. Ernest for the first time moved toward the group, helped to pass around the coffee—a reasonably relaxed feeling.

Group began to pick up the discussion again about having to come to occupational therapy. Ken seemed less provocative as he raised this question, however. The occupational therapist suggested that it might also be possible to arrange some trips together if they wanted to. Several agreed this would be a good idea but went no further. John, who had stopped working, was standing at the end of the table and was joined by Frank. Bob, Mack, and Mel joined the group at the table. Pat brought up his hobbyhorse "project" again and there was further discussion. The occupational therapist pointed out that the idea had merit and perhaps they might like to consider making these for the children's service or for some other purpose. Both Mack and Bob liked this idea and agreed to talk among themselves about it. Even Ken seemed drawn into this but said he would prefer to take a trip. It was suggested that perhaps they could do both.

The next few sessions of the group showed marked increase in interaction. Pat, Ken, Bob, and Mack were busy working on their project, and John was leaving his billfold more frequently and standing off to the side of this group, listening. During coffee breaks, the group had talked further about trips and had been able to bring up their hesitancy about going out in a group and being identified as from the hospital. This had led to some discussion about "being sick" —how "others" felt about this, etc. Ernest was able to say he would like to go to a ballgame.

During this time, Mel's anxiety seemed to increase, as did his "horseplay." The occupational therapist had discussed his behavior at a clinical staff meeting, stating that it seemed related to the increased involvement and participation of

the group and to his fears about being expected to become involved in any "doing." Mel had given the nurses a particularly bad time one evening, and his doctor, in discussing this with him, attempted to draw a parallel between his behavior and his fears, using his behavior in occupational therapy as an example. Mel became extremely angry, shouting that the occupational therapist was a "squealer" and "no good." He told the other patients that the occupational therapist was talking to the doctor about them.

The next day the patients arrived for occupational therapy in a very sullen, angry mood. Pat stated, "We were going to boycott O.T., but we wanted to tell you first." The group began talking in a very angry way about the injustice done Mel and all of them, saying that they were being "betrayed," that occupational therapy had changed—it used to be "free," "off bounds to doctors"—that now they were analyzed, it was like group therapy, etc. Tension and feelings high, then silence, group looking very uncomfortable. The occupational therapist pointed out that they all knew she went to staff meetings regularly, and they all knew the purpose of the staff meetings. The group then began to talk about the role of the occupational therapist and what occupational therapy was all about. The occupational therapist suggested that perhaps it would help to talk about why they saw this as a "betrayal." The group left still angry but also seemingly somewhat guilty about their overt expressions of feeling.

At the next session the group arrived late, bringing books, newspapers, a radio, etc. Atmosphere very cold. Only three patients began working on their projects; the others sat sullenly—Mel with his radio, the others reading. After some time, the occupational therapist remarked on the "cold atmosphere" and suggested that something was going on. No

response—silence for many minutes. The occupational therapist again stated that they were obviously still very angry, and this needed to be talked about. Ken then began attacking the occupational therapist, saying she was incompetent, rigid, etc. Pat interrupted him with the remark that "Miss L. is a lady; we're discussing her O.T. policy, not herself." Mel agreed and seemed somewhat subdued by all that was happening. Don continued to be removed and looked extremely anxious. Ken then began his usual list of complaints about being controlled—having no freedom, not being able to make decisions, etc. The occupational therapist pointed out that she saw this as something of a distortion and called the group's attention to the joint project they had initiated, the trips they were planning, and the arrangements they had been able to make about having coffee and cigarettes in the kitchen. The total group was involved at this point. John succeeded in making a statement and seemed pleased to have done so. There was good discussion about how they felt with some attempt to begin to raise questions about why they felt this way. Frank and Ernest both coming further into the group but still quite silent. Mel suggested they have coffee and volunteered hesitantly to help Pat get it. Mack reminded the group of Ernest's suggestions about going to a ballgame, and there was animated discussion about this. Mel pointed out some reasons why such a trip would not be a good idea—group rejected them. It was decided to go, and Ken emphasized that this was "on the volunteer basis." The occupational therapist pointed out that getting angry at her had not jeopardized the group.

These patients have now begun to function as a group, and there have been some movement and change on the part of each member. The occupational therapist's capacity

to allow Pat sufficient freedom to meet his needs to be in control, to manipulate things and people, and to compete successfully through an activity, and at the same time set limits and provide guidance in reality testing, made it possible for Pat to emerge as catalyst for the group to his and the group's benefit. Thus Ken was able to be drawn in by Pat and to do things with him because they were not related directly to doing things for a female authority. In addition, the hobbyhorse project provided an opportunity for Ken to use his skill in drawing in a constructive, contributory way in a masculine situation.

Because there was no pressure placed on Mel to produce, and since there were concrete opportunities for him to observe the actions of others and the results of such actions, he was able to express his anger and see this result in a positive experience for himself and the group. He was thus able to do something positive for the first time when he offered to get coffee and at the same time atone for his guilt. His behavior in the hospital has changed in that he is less provocative and has begun to work seriously in psychotherapy.

INDIVIDUAL PROCESS 1

David G., a 27-year-old man, was admitted to the hospital with the diagnosis of schizophrenia, paranoid reaction. He is the youngest of five children whose father died when the patient was 17 years of age. He completed the tenth grade and was an above-average student. After six months' courtship, at the age of 25, he married a woman several years his senior. After several months of marriage, he began to drink excessively, lost his job, and has not been able to work since that time.

Prior to admission, the patient became increasingly de-

pressed and worried constantly about the financial situation of his family, particularly since his wife was about to have a child. His wife had him arrested for nonsupport and refused to live with him. He made several attempts at reconciliation and, when these failed, attempted suicide by taking an overdose of aspirin. He then called his wife, telling her what he had done. She called the police and he was put in jail. On release from jail, he was referred to a mental hygiene clinic for treatment. He continued to be extremely depressed, became confused, walking the streets for days without food, and heard voices calling him a "bum" and telling him that he was no good. He attempted another reconciliation with his wife and, when this failed, made another suicidal attempt by hanging.

The patient states that he is no good, has let his child and wife down, and is not fit to be a father.

On psychologic examination the patient showed little overt anxiety in this situation. He seemed rather flattened emotionally with somewhat inappropriate affect. The examiner related that the patient cooperated well in a dependent manner and verbalized his delusions freely, being neither evasive nor defensive about them. He revealed depression, however, and some hostility toward the hospital as he felt then that "there is nothing wrong with me" and was anxious to see his newborn daughter.

On the Wechsler-Bellevue scale he received a full-scale IQ of 114, verbal IQ of 108, and performance IQ of 117. There was very little subtest scatter, immediate attention span being the only area of retardation. There was some slight indication of loose association, but generally the test revealed well-preserved, intellectual functioning of above-average intelligence and no evident deterioration.

The Rorschach protocol, however, was indicative of a well-developed schizophrenic break. Productions were overelaborated, loosely associated, autistic, and bizarre. The patient showed strong inner promptings and some capabilities of handling these, but his control was poor when stimulated by environmental stress, and he tended to break with reality under such pressure. Overemphasis of human beings with staring eyes—the arbitrary cutting off of parts of the blots —was indicative of a paranoid process. The patient was able to perceive reality well enough, but his bizarre perceptions were equally real to him, although these seemed to be more or less restricted to a certain area rather than manifesting themselves throughout the patient's behavior. Good intellectual preservation and strong ambitious strivings were shown, but hostility and depression were also indicated. The impression given was one of a dependent, depressed person, emotionally somewhat flat and inappropriate. He seemed actively delusional but able to perceive reality well, bizarre ideations being restricted to the delusional area.

During the first three months of hospitalization, the patient was seen weekly for therapeutic interviews by the psychologist. During this time his relationship with her was quite dependent. On the ward the patient attended the recreational activities regularly but without interest, and it was not until four weeks prior to his discharge that he participated with spontaneity in competitive sports. There was little contact between himself and the ward personnel, and he remained rather removed from nursing staff and other patients.

Treatment objectives in occupational therapy were to increase ego strength and self-esteem by having him make something for himself and encouraging the expression of

hostility through the use of metal hammering. The patient's physician felt strongly that metal hammering was indicated and that this experience was important at this time.

When the therapist first contacted the patient, he returned the greeting in a rather guarded, suspicious manner. It was explained to him that Dr. —— had talked to the therapist about the patient and asked that she work with him in an attempt to help him get well. He was told briefly that occupational therapy would help him feel more comfortable and assist him in dealing with some of his problems. An appointment was made for him to come to occupational therapy the next day.

The patient evidenced little interest in metal hammering but agreed in a hesitant, docile manner to begin the project. His first attempts to shape the metal were unsuccessful since he exerted little energy, pounding the metal in a very hesitant fashion. He was encouraged to hit the metal harder, and he accepted this just as he had the original idea, following directions passively. It was obvious that each aggressive stroke was uncomfortable to him; he became increasingly anxious and tense, and the session was terminated.

The patient continued to be tense, anxious, and suspicious to the extent that the sessions usually had to be discontinued early. He dealt with the therapist in an aloof, suspicious, and withdrawn manner. It was decided to discontinue the aggressive activity and allow the patient some time to feel more comfortable with a passive, more pliable medium.

When a second project was discussed, the patient hesitantly asked to be given no more metalwork. The therapist agreed and decided to go along with the patient's request to do some drawing. In this activity he reflected similar timidity concerning the expression of hostility in his small, formal, childlike drawings and neat coloring with penciled

outlines. He was also unable to handle the freer medium of charcoal or to use large areas of paper.

He continued to be seclusive, rejected the group of patients, approached the therapist only to request materials, and continued to seem quite unsure of his acceptance. He made no demands on the therapist, other personnel, or patients, never asking for help or comment and continuing to be somewhat guarded and suspicious, as indicated by his brief answers to questions and his averted gaze. However, he did not totally reject the therapist since he accepted and tried her suggestions before deciding whether to use them. After receiving help and just before leaving the clinic, the patient always thanked the therapist for her assistance.

At this time the therapist decided that leatherwork would better meet the present needs of the patient, because of his evident anxiety in an aggressive activity and because of the rather compulsive nature of the drawings he had made. Leatherwork was discussed with the patient, and he rejected the idea of making anything for himself. He did ask that he be allowed to make a pair of leather shoes for his baby, choosing the project from a book containing complete instructions. This activity facilitated independent performance and gave the patient little need to rely on the therapist for guidance. In view of his previous behavior, it seemed that this choice tended to minimize for him his indecision and dependency.

On completing and presenting the shoes to his wife, the patient appeared pleased, and it would seem that he had atoned in some measure for his neglect to his child, thus partially relieving his indebtedness. This was also evident in his beginning a wallet for his wife without delay and working industriously until its completion. For the first time the patient showed initiative in planning and executing the

project and displayed the ability to carry out verbal and and written instructions without difficulty. He was also able to rely on the therapist for guidance and direction and could occasionally seek help from her when it was needed.

During this period the patient became more spontaneous with the therapist and was able to talk about himself, his family, and some of his problems. He showed constant need for reassurance and acceptance and would stop talking whenever he felt he might be taking up too much of the therapist's time. When he met the therapist in the corridors, he would always wait for her to speak first.

After returning from a week-end visit to his wife, in which he had taken her two projects, he spontaneously said he thought he might like to make something for himself. After he completed a leather project for himself, the therapist suggested that he begin some wood carving. This was suggested since it contained many of the obsessive features of leatherwork, which met the patient's needs, and because it offered a more resistive medium with some destructiveness. The patient readily accepted this suggestion and was able to handle the more aggressive, destructive activity with comfort and satisfaction.

Gradually the aggressive performance was increased to include carpentry. At this time the patient was able to meet and deal with the therapist in a more adult manner, asking for assistance when it was necessary and evidencing less need for extremely compulsive performance.

INDIVIDUAL PROCESS 2

Lloyd P., a 27-year-old male catatonic schizophrenic, had been hospitalized for three years. He was extremely re-

gressed, confused, incoherent, negativistic, and untidy, refused to leave the ward, and was hostile and assaultive when coerced. During these three years several unsuccessful attempts had been made to get him off the ward and into some activity. He was at various times assigned to rake leaves, mow lawns, and work on the farm. The patient refused these activities, however, remaining for the most part on the floor of the ward in a crouched position, becoming quite assaultive when attempts were made to force him into an activity.

The occupational therapist had noticed him sitting on the floor several times, became interested, and spent several minutes each day talking to him. These contacts were repeated each day in spite of the fact that the patient did not verbally respond. He later began to look up at the therapist when she approached him.

After many weeks, the patient was finally able to work with the therapist in finger paints, on the ward, smearing the paint on his hands and face as well as on the paper and table. After four weeks of working in this manner, he one day spontaneously asked if he might wash the paint from his hands. He was at this time invited to the occupational therapy room, and although he did not verbalize an answer, he came willingly with the group. He was never pushed or encouraged to participate in an activity and was placed in a corner removed from other patients. When he did work with the paints, it was voluntary and without suggestion from the therapist. It was felt that an activity was unimportant and that the patient's need for an accepting, reassuring relationship was of utmost importance. Thus the therapist spent considerable time with the patient, sitting next to him as she worked on preparation of projects and other jobs.

During this month the patient spoke infrequently and

usually in monosyllables. One day he asked if it might be possible for the therapist to arrange for him to have a clean shirt. This arrangement was made with the ward, and the patient seemed quite pleased. He began to be concerned with his personal appearance, and a marked improvement was noted in this respect. He also began to be aware of some of the routine and would voluntarily assist in cleaning and in putting tools away.

There was little information available about this patient, and it was necessary for the therapist to rely largely on her observations. No treatment was being given him on the ward, and the only activity available to him was occupational therapy. The therapist felt there was much underlying hostility, as evidenced by his abusive language on the ward and assaultiveness when coerced. However, this seemed to be manifested only toward male personnel, and his attitude toward female personnel was rather passively negative. With the therapist, the patient twice accidentally spilled paint on her shoes and once brushed close to her with the result that his paintbrush stained the sleeve of her dress.

Since the therapist felt that the patient was relatively comfortable with her at this time, wood carving was suggested to afford him a release for his hostile, aggressive feelings. This activity seemed advisable because of the relative resistiveness of the material and because it offered a destructive act, well organized and controlled. The patient's workmanship was above average, and he seemed to derive much satisfaction from the act of cutting. He worked carefully and persistently on the project and asked to have his period increased to a half day. When the project was completed, he presented it with a pleased expression to the therapist, and this was accepted by her with genuine apprecia-

tion. His next project was a larger carving project requiring heavier, more aggressive motions.

The therapist continued her original plan of devoting a minimum of 15 minutes each morning exclusively to the patient, in addition to the time spent in assisting him in the project. During this time the patient talked about his parents, whom he had not seen since his hospitalization, a sister of whom he was very fond, his various jobs, and the difficulties he had had at home.

After eight months, in which a very sound relationship developed between the patient and therapist, the patient was wearing his own clothes and was neat, coherent, and spontaneous in his dealings with other patients in the group. He had renewed his interest in reading and had been granted ground privileges.

The therapist then contacted the social service department about the patient, and the social worker arranged for the patient's sister to visit him. At the same time the therapist referred the patient to a vocational guidance counselor for testing, with a view toward assisting the patient in establishing a posthospital vocational goal. On the basis of these tests and his performance in occupational therapy, it was suggested that he attend the hospital sheet metal shop for the purpose of learning metalwork skills.

He evidenced interest in this, and the therapist took him to the shop several times so that he could get to know the instructor and become familiar with the shop. Occupational therapy was then discontinued, and he was scheduled to attend the sheet metal shop. After his first morning there, he returned to the ward, refusing to continue with the assignment. He was seen by the therapist and the situation was discussed. It was apparent that the patient was fearful about

the threat of a new situation and felt inadequate to it. He returned to occupational therapy, and no attempt was made to discuss a probable return with him. He was less spontaneous, rather quiet, and depressed during this time, asking for more guidance and approbation than he had in many months.

After several weeks, the patient spontaneously volunteered to give the metal shop another trial. It was suggested to him that he arrange his schedule so that he could spend a half day in occupational therapy and a half day in prevocational training. This was done in order to wean him gradually from his dependence on the occupational therapy situation and to provide him with a familiar and secure relationship during the early period of adjusting to a new and challenging situation.

The patient gradually became engrossed in his activities in sheet metal, finding less and less time to come to occupational therapy. He had an excellent relationship with the instructor and, on completion of the course, had surpassed all others in development of skill.

The social service worker had continued to work on the problem of his family and had completed arrangements for his sister to give him a home. He was able to secure a job with the local tinsmith and was discharged. The patient was seen after six months and then a year later. He has been out of the hospital for several years and is making an excellent adjustment.

INDIVIDUAL PROCESS 3

Since his admission, *George K.* has been tense and anxious, with alternating periods of hostility and depression. The patient was an only child whose mother left him when he

was quite small. The mother would return to the home periodically, remaining for short periods, only to become involved with another man and leave to live with him. During her visits at home, the mother drank excessively and was alternately effusive in her concern for the patient, punitive, cruel, and abusive.

The father assumed responsibility for rearing the patient. They were together constantly, and the patient was very attached to his father. The patient had been married twice. The first marriage was to a woman 10 years his senior and ended in a divorce. The second marriage was no more successful than the first, the patient being constantly suspicious of his wife and accusing her of infidelity.

As a child, the patient was extremely shy and insecure, with extreme feelings of inadequacy. He felt inferior to other children and always felt that the teachers and others were laughing at him because of his stupidity. During adolescence, the patient learned to defend himself in a pugilistic manner and became known as the neighborhood bully. He has remained deeply attached to his father and extremely hostile and sadistic toward women.

After admission to the hospital, the patient was assigned to a psychotherapist for individual psychotherapy and sent to occupational therapy, the purpose of which was to provide an accepting, reassuring relationship, re-establishment of obsessive-compulsive features, and a constructive expression of hostility.

Psychologic Tests and Interviews. The patient was talkative, at times agitated. His face easily got flushed. In talking about his family, he manifested a great deal of bitterness about his mother, who was the "flighty type." He stated that he never received any help to get ahead and had to

get everything "the hard way." Nevertheless he graduated as valedictorian from high school and worked his way through two years of college. The patient appeared anxious, quite unrealistic, and somewhat grandiose.

During the testing, the patient showed excessive concern about his own performance. "Am I doing this right. . . . You got me down for an IQ of 50. . . . I know I am afraid of making mistakes. It has been this way all of my life. I am afraid people laugh at me. . . . In one way I like to take the test, but then something says not to do it. I know I can't go back to my job again this way. They could not tolerate that stuff." The patient responded well to reassurance, and in spite of frequent digressions into his preoccupations, he gave a fairly consistent test performance.

The Wechsler-Bellevue scale indicated "bright normal" to "superior" intellectual ability. Full-scale IQ was 120; verbal IQ, 118; performance IQ, 120. Subtest scatter did not show a significant diagnostic pattern. A deterioration loss of 15 per cent beyond normal age decline suggested a mild impairment involving new learning. However, there was no significant impairment of abstract thinking. This was substantiated by the results of the Shipley-Hartford scale, "Conceptual Quotient—107." Qualitatively, these tests showed no bizarreness or faulty associations, but compulsive perfectionistic tendencies and the desire to impress the examiner with a superior performance.

The Rorschach test of 16 responses showed, primarily, evasiveness and repressed hostility. In this test, where the patient felt particularly insecure, he constantly vented his underlying aggression in criticism of the blots and in the attempt to project his own inadequacy onto inadequacies of the test material. At the same time the patient seemed to

feel constant guilt over these aggressive promptings, and he tried to cover them up by an overdemonstrative emphasis on beautiful aspects of the cards. The Rorschach test was rather striking in its evidence of projected hostility alternating with guilt feelings and an impoverishment of content and originality, which is in contrast to the patient's superior intelligence.

The thematic apperception test and the sentence completion test again emphasized the interplay of hostility and feelings of inadequacy, worry, and guilt. The motive of marital jealousy was projected in TAT. Concern about his family was overstressed.

During the first two hours in occupational therapy, the patient took every opportunity to impress the therapist with his intellectual capacity, education, and abilities. He told the therapist that he was a criminal lawyer and spent much time discussing his accomplishments in this field. He attempted to engage the therapist in a discussion of psychiatry and succeeded in impressing her with his educational background and intelligence.

After the first contact with the patient, the therapist was startled to discover that the patient's story to her was not substantiated. She expressed annoyance at the patient and herself for being "taken in." During the second session, the therapist spent much less time with the patient, paying little attention to his talk, which was similar to what he had expressed during the first session. After this session, the patient sought his doctor and requested that he be removed from occupational therapy, stating that he did not like the place or the therapist and felt that she did not like him. The patient was then transferred to another occupational therapist.

In his contact with this therapist, the patient made no

attempt to impress her and readily accepted her suggestion of an activity. He was quite dependent on the therapist for approval and decisions, requiring a considerable amount of guidance and reassurance. His activity performance was far above average, and his projects were executed in a skillful, meticulous manner. He remained in this area for three months, continuing to perform in a perfectionistic, dependent manner but with increasing ease and spontaneity in his relationship with the occupational therapist. At this time the patient was transferred to another building, necessitating a transfer to another occupational therapy group. The third occupational therapist was a man. For the first few sessions, the patient continued and completed with the same skill and excellent craftsmanship a project previously begun. He gradually, however, began making more and more demands on the therapist, refusing the suggested activity and insisting on working in leather. Each day he complained bitterly that Mr. ——'s leather was inferior, that the tools were in too poor a condition to use, or that numerous other pieces of equipment were not as they should be. He told everyone that the therapist paid no attention to him and that he got no help from him and had to shift for himself; all this was in spite of the fact that the therapist made special trips into town on his own time to purchase exceptionally good leather, that he gave the patient new tools, and also that other patients were beginning to complain that the therapist was spending so much time with the patient that he was neglecting them.

The patient's complaints continued; he annoyed others in the group and began having outbursts of temper. These outbursts were always directed toward the therapist and became increasingly severe, until one day, in a fit of temper,

the patient attempted to strike the therapist. It was also interesting to note that during this time the patient's activity performance was quite inferior to his previously demonstrated abilities. His projects were poorly executed and carelessly done, with little or no attention to detail.

At the same time the patient's behavior on the ward did not change. He did not get into similar difficulties on the ward and was able to conduct himself in such a manner as to warrant continuation of his privilege status. In the light of his previous behavior in occupational therapy, on the ward, and in psychotherapy, it was felt that his behavior in occupational therapy at this time was the result of the particular interpersonal situation between himself and the occupational therapist.

Several consultations with the occupational therapist, the occupational therapy supervisor, and the psychotherapist were held to analyze the situation. The therapist admitted disliking the patient from the first and feeling hostile toward him. He was able to recognize attempts on his part to compensate for these feelings in special attentions, which only served to increase the patient's anger and guilt. Since the patient's anger and hostility had always been directed toward women, it was difficult at first to understand such extreme hostility verbalized against a male therapist. An analysis of the occupational therapist's way of relating to patients indicated a permissiveness, protectiveness, and concern resembling the mother role. The patient's behavior was thus more readily understood in the light of the personality of the therapist, coupled with his hostility toward the patient, however well concealed he felt it was by special attention and considerations.

In considering the patient's relationship with the first oc-

cupational therapist, it was felt that a therapeutic relationship had been impossible because of the therapist's failure to accept the patient according to his personal worth and on his own level. Because of this and also because of her need to be impressed by the patient, she encouraged him in his intellectual discussion. She thus immediately placed herself in the position of accepting the patient for what he said and valued him for his knowledge rather than for himself.

The patient returned to the second occupational therapist, where his adjustment was the same as it had previously been. Although he was quite dependent on the therapist for approval, he continued to be more spontaneous and free in his relationship with her. His performance returned to the previous high level, and it was eventually possible to transfer him from occupational therapy to the hospital greenhouse, where he received some prevocational training.

INDIVIDUAL PROCESS 4

Carol G. is a 21-year-old, gifted, intelligent girl who is described as "a bright oriented girl whose sense of helplessness, rage, and terror is severely crippling. Running away is the only response she knows to a world she perceives as hostile and threatening." At the time of admission, she was almost mute, with alternation between periods of complete immobility and violent banging of her head against the wall. She was extremely emaciated from a long period of rejecting food because of nausea and severe stomach cramps. She has an older sister and a younger brother, both of whom have had psychiatric treatment for problems that developed during their first separation from home.

Carol is the second of three children in a very closely knit,

self-contained family. Her father was a research scientist who died suddenly during Carol's adolescence. She seemed to feel closer to him than to anyone in the family, although he was an aloof, quiet man and described as "difficult to get to know or understand." Carol has always felt that her father really wanted a boy and that he remained disappointed in her because she was a girl. She recalls a few times when they went boating or walking in the woods together as "the only good times" she ever had. She has some sense of guilt about his death but is unable to talk about the incident. Her mother is an accomplished artist who has controlled and overprotected the family. She is described as "an obsessive-compulsive paranoid woman who has made it impossible for her children to grow up." The mother had ambitions for the children to sing professionally as a trio and was a strict disciplinarian in terms of their practice and work in this area to the extent that she prohibited any other kind of activity. The children had little real contact with persons outside the family, and peer relationships were discouraged.

Carol did very well academically in high school but made no friends and was expected to return home immediately after school in order to rehearse. She received a college scholarship, but her mother felt she was not ready for this and arranged for her to study voice at home. The following year Carol entered college and began to experience severe anxiety, a "tenseness and cramps in my stomach." These feelings continued; she cried constantly, was unable to eat, became unable to leave her room, and was finally hospitalized at the college infirmary. Psychiatric treatment was recommended, and she entered the present hospital.

During the first several weeks of her admission, Carol would lie curled up on her bed or on a couch clutching her

stomach. During these periods, she was uncommunicative, withdrawn, rigid, and totally unresponsive. At other times she would race across the room and bang her head against the wall, and on one occasion she sustained a concussion. She received some relief from medication and began to be able to spend brief periods of time sitting in the dayroom. However, her movements and responses were extremely slow and guarded; any interpersonal contact would precipitate severe stomach cramps, and she would withdraw to her bed unable to move.

An occupational therapist had been working on the ward with a small group of patients, and when Carol was in the dayroom, she would sit quietly next to her. When Carol was in bed, the occupational therapist would spend some time sitting with her and bringing her coffee. After many weeks, Carol was finally able to drink the coffee. She began to frequent the dayroom when the occupational therapist was there but was extremely wary of the situation, avoiding other patients and remaining off to the side of the room. These contacts continued, and gradually Carol began to speak hesitantly and slowly, saying such things as "I'm a failure," "I won't ever be able to do anything," "You're wasting your time." She was reassured and told that the occupational therapist's desire to help her was not contingent on her "doing." Carol's tolerance for these meetings was initially quite low, and they usually lasted no more than 15 or 20 minutes. Gradually her capacity to sustain contact with the occupational therapist improved, as did her ability to verbalize some of the emotions she was experiencing. There were fleeting times when she appeared to be reaching out and making a real effort, but these would be immediately followed by withdrawal, head banging, or disabling stomach

cramps. The nurses became increasingly concerned about her behavior and their inability to reach her. Carol and the therapeutic problems she presented were discussed at clinical conference. It was pointed out that this patient had a parasitic relationship with her overprotective controlling mother, whom she saw as all-powerful, invulnerable, and unloving. It was felt that this girl was reacting with a catatonic withdrawal. It seemed at this time that Carol was beginning cautiously to respond to the occupational therapist and that this should be encouraged and the relationship developed. Thus it was decided that, in addition to interview psychotherapy, Carol would be seen in individual occupational therapy sessions three times a week. The occupational therapy experiences were to be directed toward the development of a relationship with a female figure sufficiently giving and supportive to allow her to experience and understand an involvement that was gratifying to her and unlike her expectations. And activities were to be used to help her communicate feelings, become more aware of these feelings, and deal with the meaning that action had for her.

During the next six months, the nature and quality of many of Carol's problems became more evident and better understood. The meetings between the psychotherapist and occupational therapist provided excellent opportunities to assess her thinking and functioning in different settings and to arrive at a consensus about treatment. It became evident that Carol perceived these two persons in much the same way as she had her parents, and the collaborative relationship of occupational therapist and psychotherapist made it possible to understand her behavior better and to deal with it to her benefit.

Her response to experiences in occupational therapy

seemed to help her to see some of her major difficulties in functioning and helped make it possible for her to begin to explore them and to be less frightened by them. Her lack of ego strength and a self-concept was evident several times when she became frightened and talked in a confused way about not knowing sometimes whether "I am Carol or you or a bit of each"—"It gets all mixed up." On other occasions during activities, she would have difficulty knowing whether she or the occupational therapist had just made the coffee, wedged the clay, or done the knitting. After one of these experiences, she talked about a time when she was sweeping and became confused, wondering how she had come to do this, began to feel she was the broom, and described this as terrifying, stating that it was at times like this that she would bang her head.

Her fear of involvement with people or things in any way seemed to be associated with a feeling of loss of self as well as an expectation of rejection and failure, and these feelings were demonstrated in her response to action in occupational therapy. For example, at one time, when she was working with a lump of clay, she began to be evasive, circumstantial, and confused, doubled up with stomach cramps, and was unable to move. Later she described this experience as a feeling that she was the lump of clay—"I couldn't tell what was me," "It's hell," "I am nothing, yet I want to be." These experiences of fused identity seemed to be precipitated by touching or being touched and, while they occurred more readily with unstructured material, were evident at times even in the process of knitting. Similar incidents with other objects elicited this sensation, a "freezing from involvement" or perhaps a protection from total loss of self.

Carol's feelings of anger and her terror at not being able

to control these rages, which she perceived as totally destructive, were seen, for example, in her response to the aggressive action in wedging clay. At this time she became incoherent, fell to the floor holding her stomach, and was completely immobile for several minutes. This was followed by uncontrolled weeping. This time, however, she responded to the occupational therapist's reassurance and support and was able to talk about her fears of loss of control—that she would throw the clay across the room and "destroy everything." Her difficulty in becoming aware of her angry feelings was attested to by her talking about "feeling uncomfortable" when she is pushed or forced to do something or when she feels she is expected to perform in occupational therapy. Another time, when Carol and the occupational therapist were returning to the ward, the therapist's key became wedged in the lock. The occupational therapist expressed some mild annoyance and jerked the door forcibly. Carol became very upset, her body stiffened, and she said she felt as though she were going to have stomach cramps. She talked again about confusing herself with the occupational therapist and about being frightened because the occupational therapist was angry—"We were together and we would get hurt." This was not unlike the sensation she had verbalized before that at times they were one and the same person, controlled by the same feelings and impulses. It was necessary each time to point out clearly the real differences between them and to reassure her that the occupational therapist was in control, saying in effect, "I am not going to let you hurt yourself or me."

Carol's poor capacity for reality testing was further evidenced in other perceptions about people, things, and incidents. The rather tenuous line between reality and fantasy

was demonstrated on one occasion when they were cooking and Carol, in response to the oral infantile stimulation of food, began to associate this with an experience she had had as a child with her mother. As she talked, she became more and more confused, mixing up the two experiences, and for some time was unable to recognize the realities of the immediate situation. At other times, she would talk to the occupational therapist about what was going on in psychotherapy and about Dr. ——, and her difficulties in being able to determine what was real and what was fantasy were clearly evident.

Her overwhelming sense of helplessness was shown in all her responses and behavior. She was completely unable even to try to remedy a simple mistake in her knitting and became extremely frustrated with this. The incident of clay wedging when she was helpless to deal with her terror and her reactions to a finger-painting experience in which she became overwhelmed at not being able to "do anything" and wept in a very helpless manner about being a failure, worthless, and hopeless are some examples of these feelings.

Her fears of involvement, her need to control her rage, to guard against exposure, her frequent concrete thinking, and poor reality testing made communication with others extremely difficult and increased her feelings of helplessness.

"Doing" or action is replete with all sorts of dangers and commitments for her. Her mother's pushing and emphasis on accomplishment add additional meaning to performing in any way. Thus Carol's occupational therapy experiences have had to be slowly and carefully chosen and worked through with her.

The plan was to provide a supportive, dependent, reassuring relationship, directed toward gratification of her in-

fantile needs. Food was used as the initial activity because it provided gratification of infantile oral needs, and later other mother-and-child experiences, such as shopping, walking, and reading together, were used. Her fear of action made it necessary to introduce activities cautiously and without pressure and only as the relationship became increasingly supporting and reassuring to her. Highly structured, repetitive, and predictable activities were used to increase her sense of control and organization and to provide support and reassurance to venture further in exploring increased activity. Ultimately finger paints and clay were used to provide opportunity for her to begin to explore experiences in freer, less-inhibited, and more aggressive action. The cooking and eating experiences were finally used to elicit further response to this infantile oral activity and help Carol express some of her feelings and needs in this area.

Occupational therapy is the antithesis of catatonic behavior, and attempts to involve this patient in activities have been successful only as the relationship has become increasingly supporting and reassuring to her.

The following material presents some excerpts from notes kept on each session with Carol. They are presented as they were written in order to give some impressions of the occupational therapy experiences.

Carol moving very slowly, stiffly, and looking quite depressed when I arrived on ward but wanted to leave with me. We went to the kitchen. She slumped in chair—let me make coffee for us. Talked about total hopelessness—no one understands—she is beyond help. Expressing feelings or trying to do something makes it worse, not better. Expects me to give up when she does not perform—afraid this would make me "hate her." Saying I should give up trying. I pointed

out that our sessions together were not contingent on her doing. I would not give up and would always be here. Talked about a planned shopping trip for next session, and she stated she could not go—"No point to it"—"Why should you waste your time?" I reassured her about this and said the decision was hers.

Session after shopping trip. Carol very withdrawn today, seemed anxious and uncomfortable—forced movement and conversation. Had purchased dough Tuesday and she wanted to go ahead with plans to bake cookies. Became more active while cutting out dough but asked not to do any more —said she wanted to talk. Talked about "uncomfortableness" when she is pushed or forced to do something. Focused on shopping trip yesterday, saying she felt uncomfortable and pushed to keep in step with me and keep walking, do shopping, etc., or I would be angry. I asked her if that was why she went in the first place—said she did not know. I pointed out she had said she did not want to go and perhaps she could not follow through on her feelings. She said, "Afraid to express real feelings" because I would stop seeing her. Difficulty in enjoying anything—only negative feelings—like yesterday. I talked only about negative feelings on shopping trip. Silence. Suddenly she appeared anxious and slumped over holding her stomach—said she was tired—did not want to talk any more. We sat in silence and then returned to the ward. Feel both cooking today and shopping yesterday were too much—relationship of these to her infantile needs and feelings about mother create anxiety and she feels a sense of pressure.

Went on the ward to get Carol today. Discovered from nurse that she had returned from group therapy very upset—had thrown her purse against the wall and bruised her

hand—crying and out of control—did not eat lunch and was in bed. Went to her room. She was looking very miserable—sat with her. She said she wanted to go make coffee with me but "Please don't make me do anything more." I told her I had no intention of "making her do anything." While I made coffee, she talked about being very angry with Dr. —— [her therapist]. "He hasn't helped me at all." Said she was feeling "hopelessly angry" at him for not doing anything for her (feel perhaps she may be speaking about her anger with me but do not dare raise this now—too touchy). Began to tell me about group therapy session—a patient had lost control and left the session—Carol extremely frightened—talked about her fears of losing control, of not being able to handle her feelings—"They just boil up inside me." Was able to say she did not deny them all the time any more, but feels so "frustrated" because she cannot handle them. Silence. I suggested that Carol do some of her knitting. She began to knit and then poured cup of coffee for us. Talked about expressing feelings to another—"Can't do this—they're all negative." "You might say things which would hurt the other person." Silence. "If you tell a friend how you feel, then you don't have a friend any more." I reassured her that getting angry with me was not going to chase me away—I could "take it" and it would not destroy me. Her immediate response was that I could say this because I was not really involved with her—could not really be hurt. I assured her that I did have positive feelings about her and that I was not overwhelmed nor would I be destroyed by the relationship. Suggested that she knit because the repetitive, organized, structured pattern and process help Carol to experience a sense of control and are helpful when she feels she might lose control.

Introduced her to clay today. Had talked about this before—she had many misgivings but agreed to try. We began wedging clay. I was supportive but direct in what I wanted her to do. Initially her main concerns were about doing it correctly—keeping clay on the wedging board. Began making joking comments about throwing clay around the room—at me. I reassured her about the "safeness of clay." She pulled together briefly, then went to pieces—sobbing that she could not control her feelings and that I should give up—stop trying. Talked in a confused manner about "ruining the room"—"destroying everything." I pointed out to her that this had not happened—she had control of the clay—we were still here. She became calmer, talked again about my losing faith in her—the sessions would stop. Again reassured her that angry feelings were not necessarily bad nor would her anger "kill our relationship," that as she better understood her feelings, they would be less of a problem. She suggested we make coffee—much calmer then—talked about her mother never listening to what she said, only making her keep her feelings "pushed further and further down inside." I said I was here to help her.

This was a good session following the "clay episode." Went to pick up Carol on ward—found her in reading room listening to records—looking good—greeted me with her first smile. Went to occupational therapy room, which was in chaos from my group. She laughed at the disorganization —went into the kitchen—helped to make coffee. Said she would like to learn to crochet when her sweater was finished. Talking rapidly—pressure of words. Said she had a good session with Dr. —— and for the first time she had felt somewhat in control—had really been participating—not just being led and pushed—wondered if clay had helped.

Talked about her fear of doing knitting but said it was only in getting started. After that, doing it made her feel more in control. Began to talk about why she thought she was sick —rambled—difficulty in following her. Said things about her mother's feeling that she [Carol] was bad when she felt good—mother had to teach her the "right" way to act. Talked more about feeling in control—then wondering if she could really get angry at Dr. —— (me?). Asked if we should wedge some more clay—"If that really helps me." She wedged clay in a more controlled manner—seemed extremely cautious and to be testing—stopped shortly after she began but was pleased to have accomplished this without falling apart.

Several good sessions. Carol continued to participate more actively and assertively: (1) Her continued awareness of and exploration into our relationship—participation as a person with thoughts, feelings, etc., that can be shared. (2) Her increased involvement in activities—knitting, crocheting, cooking, working with clay and her active exploration of what "doing" means for her—what she feels others expect of her—how it means only doing what others want. Discussed the differences between these experiences in occupational therapy and her previous "doing." Said her doctor even looks different to her now.

Carol very upset—unable to get out of bed—refused to see me. Several very upsetting experiences for her—was seen at staff and found this very trying, doctor told her he was going on vacation, a week end at home from which she returned sobbing and incoherent.

Carol still unable to get out of bed. Spent half hour with her—brought her coffee. She kept repeating, "Everything is hopeless." Had difficulty talking but seemed to want me

to stay with her—talked in frightened way: "It's too awful to tell you"—began to talk about week end at home—her "terrible feelings" about her mother.

Things have been going better for some time now. Carol has been pleased to get to sessions without my calling for her—is gratified at being able to learn an activity with ease and do well without feeling of being pushed or controlled. Has been working with clay and is more comfortable. Made face today—said it looked like a freak "like me"—"He's laughing at me"—smashed it. Talked of a terrible pain—not being able to move. But pulled herself together. Took the clay—began smoothing it into a ball and talked a bit about being ugly, a freak, and always feeling different from others, never fitting in—"Feels terrible to be so lonely"—"Wish someone—I mean you—could be with me all of the time when I feel this way." Put clay away. Said she could not talk any more but felt better—not so alone. We went out for a walk before she returned to the ward.

Planned at last session to cook today—this was Carol's suggestion. Told her when she arrived that I had to cut the session short because of pressing matter. Her reaction, "O.K. —it doesn't matter"—treated it very lightly—then was silent. Began mixing ingredients with me, looking upset. I wondered if she was annoyed at my having to leave early. She said, "Oh, no," then suddenly slumped down and looked fearful—"Why can't I tell you right away how I feel?" Talked about being very frightened—angry at herself for getting panicky—was angry at me—this was why she was frightened. Talked about having a pain in her stomach—"If I move or breathe, it will break out—used to be I just sit, just lie motionless, but last time with you I did something about it—it controls me." Silence. "Maybe I have some-

thing to do with it—can fight it—get stronger. I'm talking about it now and it's not getting worse." She went back to cooking and talked about other experiences with cooking, about her mother, some of her fears about eating—that she would get fat and "monstrous." Asked to cook again next session and took some food and her half-finished cup of coffee with her to the ward.

Carol continues to explore her relationships and her feelings. She has become more aware of others and has begun to make some attempts to understand her feeling and behavior toward others. She has talked more freely about her doctor's leaving, been able to verbalize anger regarding this, and begun to refer to her father's death. After a social encounter between herself, the occupational therapist, and another staff member, she was able to talk about her "social awkwardness" and difficulties in relating to others and showed some real capacity to look at this. Her experiences in an occupational therapy group with another therapist have provided opportunities for her to become aware of "sibling rivalry" with regard to her peers, and it is expected that continued experiences with this group will help her to deal with problems concerning competition, failure, success, sharing attention, etc. Activities in occupational therapy have provided opportunity for her to see some of the interrelations of her anger, helplessness, and fear of action. Her relationship with the occupational therapist has made it possible for her to act out and explore these actions and to experiment with her increased awareness. She is still unable to express her anger directly toward the occupational therapist, but their cooking and eating experiences together provide increasing opportunities for her to respond to the infantile feelings that food elicits and thus to explore how she

feels about eating and feeding, mothering and giving, etc. Her ego integration remains somewhat tenuous, and there are times when she becomes completely overwhelmed and retreats to her bed in panic. However, these episodes are less frequent, and she is able to understand to some extent what is going on and make an attempt to handle it.

CHAPTER 14

Occupational Therapy and Programming for the Chronic Patient

One of the more persistent reservations about theories of psychodynamic occupational therapy is the feeling that such concepts and methods may be reasonable and easily implemented in small intensive-treatment hospitals but that they are untenable by and large with groups of chronic schizophrenic patients, particularly in the larger hospitals. Surely the almost overwhelming problems of large numbers of patients and limited numbers of trained personnel are understandable and real. However, experience and experimentation have convinced us that psychodynamic programs for such patient groups in large institutions can be successfully accomplished, are appreciably beneficial to patients, and produce a higher degree of motivation in staff at all levels.

For many years, the average person has perceived mental illness as an irreversible process. Modern research and treatment have begun to effect some changes in these attitudes;

however, we must recognize that for many persons, including our patients, there are more or less conscious doubts about the reversibility of this illness. In conceptualizing programs for the chronically ill, then, we err if we fail to recognize the impact such unconscious attitudes have on program implementation. It is particularly important that constant ongoing programs of education and inservice training be directed toward increasing each staff member's understanding of mental illness, regression, chronicity, and health.

Occupational therapy procedures for the continued-treatment patient are not essentially different from those for the acutely ill. However, since these patients have been hospitalized over long periods of time, one must recognize and understand that personality disintegration may be more extensive and that in the process of making some adjustment to his psychosis, the patient may have solidified much of his pathology. Most attempts to change this adjustment to the illness or to hospitalization may be met with resistance for the reason that such interference with his present method of handling problems presents a tremendous threat to the patient. In many instances, after a prolonged psychosis, the patient has learned to adjust to his psychotic thinking and feeling with a relative degree of comfort since regression is a means of adjustment or an attempt to allay extreme, continuing anxiety. Attempts at reintegration or change are threatening since they confront the patient with returning to a former situation replete with extreme anxieties, fears, and apprehensions. The occupational therapist who deals with these patients must have a full understanding of the significance of these factors and must have infinite patience, tact, and understanding.

Regression does not mean that basic emotional needs have disappeared. True, it may be more difficult to recognize them because of the extent of regression or personality disintegration, but they do exist. It is the responsibility of the occupational therapist to establish a situation in which this person can be reached and in which his needs may be manifested and gratified in an acceptable and therapeutic manner.

Because of the extent of ego disintegration, the patient frequently relates to people and to situations in an infantile manner. On the basis of these childlike relationships and behavior one may be inclined to assume that the program planned for these patients should be on a kindergarten level in order to reach them. The occupational therapy experience should reach the emotional and volitional level of the patient, but one should always remember that these levels are individual and that one cannot establish a common level for all patients. Although the patient's behavior may be quite childlike at times, he is an adult and is quite aware of this. The patient must be treated as an adult with expectations gauged by what we know to be his level of functioning in the realms of interpersonal relationships and activities. To consider the adult patient as a child and to treat him accordingly contributes little toward helping him develop an ego concept sufficient for him to function as a responsible, contributing member of a group or society. This approach is important not only in terms of the kinds of activities but most particularly in regard to the therapist's relationship to the patient.

The importance of accepting the patient as an adult was demonstrated quite clearly in the instance of a certain patient who was quite infantile in his behavior. This patient

would, at times, suck his thumb and use baby talk, was unkempt, and behaved most of the time like a small child. It had become common practice for all who knew this patient to treat him as if he were a small child and to call him "Willy." It was significant to note the change in the patient's attitude and behavior one day when he was addressed by a new therapist as "Mr. Jones." He stood up, stopped grimacing, and answered in a more coherent adult manner.

Because such patients have been so long removed from social and interpersonal responsibilities, have so long experienced frustration and denial of their basic needs, considerable attention is necessary to daily living care such as personal hygiene, dress, and social skills and to opportunities to express and gratify more basic needs. The ultimate goal is to assist the patient in developing a self-concept and identity that will make it possible for him to function with greater satisfaction to himself and others. This can be accomplished only by consideration and understanding of the individual patient and is facilitated by a well-rounded program of therapeutic activities.

With the advent of drug therapy and the increased accessibility of the chronic regressed schizophrenic, numerous programs have developed. One of the more outstanding of these is the rehabilitation program for the chronic schizophrenic developed at Vermont State Hospital.[1] The report of this program provides excellent material on both concepts and methodologies, and every student of occupational therapy should become familiar with it.

In some hospitals the occupational therapy department is responsible for all activities of the program, including self-

[1] Chittick, Rupert A.; Brooks, George; Irons, Francis; and Deane, William: *The Vermont Story*. Waterbury, Vt.: Vermont State Hospital, 1962.

care, physical exercise, and recreation; whereas in other institutions other departments share the responsibility. Whichever is the case, the important factors are unity of purpose and uniformity of approach and understanding. The program should provide gross physical activities for the purpose of physical stimulation, release of tension, increase in mental and motor coordination, and large group participation; small group activities for the purpose of creating and sustaining group identification and an awareness of the needs of others, experimentation with relationships, competition, sharing, etc.; and individual activities for the primary purpose of providing, on an individual basis, opportunities for expression of the emotional needs and drives of the patient and their gratification.

Rehabilitation for the chronic psychiatric patient is an extremely vital part of hospital programming because of the length of time such patients have in all probability spent within an institution removed from the real world. As treatment goals are reached, a well-organized program of rehabilitation is essential for these patients.

The following program outline may illustrate the nature and quality of meaningful program planning for these patients:

In a 3000-bed psychiatric hospital, one building had come to be known as the "Idlers' Ward." This building housed some 200 regressed chronic schizophrenic male patients. Personnel consisted of one registered nurse, one doctor, and one occupational therapist. Patient care was almost totally dependent on attendants and aides, and most personnel preferred not to work in this building. Periodically, attempts would be made to involve these patients in the hospital industry program or in work on the ward with relatively little

success. The occupational therapy program of arts and crafts had also failed to make any appreciable impact. The majority of these patients were incontinent, mute, unable to dress themselves, and almost totally unresponsive to the attempts of the staff to motivate them.

A new doctor assumed responsibility for this building, and on the basis of his determination to reach these patients, he and the director of occupational therapy began to plan a program. The clinical folders on each of the 200 patients were divided among the doctor, the occupational therapist, the nurse, and the charge aide. These were reviewed for the purpose of selecting those patients who would seem to have the best prognosis for responding to a total-treatment program. When these tentative selections were completed, each of these patients was then interviewed by the staff group and a final selection was made.

Three groups of 15 patients each were formed. Group A consisted of the best-functioning patients and group C, the poorer functioning. It was planned that as patients improved and moved out of group A to other programs, they would be replaced by progressing members in group B. Likewise, group C would be filled by patients from the ward.

The program plan provided for three general kinds of activity experiences.

1. Gross muscular, physical activity such as ball tossing, marching, calisthenics, and ultimately softball, soccer, relays, etc., for the purpose of providing the values of physical activity as well as improving coordination and developing a more integrated body concept.

2. Passive table games such as checkers, cards, dominoes, Parcheesi, etc., for the purpose of helping the patient ex-

plore group relationships, become aware of himself in relation to others, and experiment with the expectations of himself and others in a small group.

3. Creative and structured arts and crafts to provide opportunity to express basic emotional needs and work toward gratification of them.

A large area in the basement of the building was used and three temporary partitions installed so that the three activities could function simultaneously without disruption to one another. Physical activities were supervised by a corrective therapist, small group games by volunteers, and the arts and crafts by an occupational therapist who also coordinated the program. Assistance was provided by a few attendants from the wards.

The schedule was arranged so that each group was involved in two different activity experiences in the morning, followed by a lunch break and then their return for the third experience. At each change of activity, the patients were taken to the bathroom and given a cigarette break. The third session, after lunch, was followed by a general session involving all three groups. At this time the total group was involved in sharing a variety of experiences such as group singing, hospital band concerts, musical entertainment by volunteers, tour of the hospital grounds and facilities (many of these patients had never seen any part of the hospital except their building and courtyard), field games, bingo, etc. Once every two weeks this time was used by volunteer groups to give a party for the patients. These parties served as additional contact with persons outside the hospital and provided opportunities for patients to begin to re-establish their social skills. Ultimately, the patient groups

were able to assume considerable responsibility for these parties.

Patients very rapidly became aware of the level of each of the three groups, and graduation into a "better group" or out of the program became very meaningful to them. The staff, including volunteers and aides, met at the end of each day for discussion of problems and as part of their inservice training.

At the end of one year, 45 patients had been transferred into the hospital industries program and were working for the hospital; 22 were sufficiently improved to be able to be transferred to other buildings for ongoing treatment; 9 had been placed in on-the-job training; 6 had entered an education program; 12 comprised a wood-working group with the carpenter, had made storage and supply cabinets for the department, and were busy taking orders for other jobs; 6 were discharged from the hospital, and 13 were discontinued as unimproved.

By the end of two years, the total character of this building had completely changed. It was seen as the "convalescent building," and personnel were most eager to obtain an assignment there.

REFERENCES

KAMMAN, C. R., *et al.*: "Critical Evaluation of a Total Push Program for Regressed Schizophrenics in a State Hospital," *Psychiat. Quart.*, Vol. 28, No. 4, 1954.

MARTIN, M. C.: "A Practical Program for a Mental Hospital 'Back Ward,'" *Am. J. Psychiat.*, Vol. 106, No. 10, 1950.

MERRY, J.: "An Experiment in a Chronic Psychotic Ward," *Brit. J. M. Psychol.*, Vol. 29, No. 3–4, 1956.

MICOLAOU, G. T.: "Evaluation of Ward Occupational Therapy with Regressed Patients," *Psychiat. Quart. Supplement*, Vol. 25, 1951.

MILLER, D. H., and CLANCY, JOHN: "An Approach to the Social Rehabilitation of Chronic Psychotic Patients," *Psychiatry*, Vol. 15, No. 4, 1952.

VON MERING, OTTO, and KING, S. H.: *Remotivating the Mental Patient*. New York: Russell Sage Foundation, 1957.

CHAPTER 15

The Impact of Administrative Procedures

It is our intent to discuss here some aspects of administration that are perceived as directly influencing the implementation of concepts we feel are basic to occupational therapy. Those that we have selected must be recognized as only a few examples presented for the purpose of providing a brief orientation to a philosophy of administration in occupational therapy.

Just as occupational therapy and all other aspects of programming and treatment are biased by the hospital culture in which they occur, so the "feeling tone" or atmosphere of occupational therapy is created by its organizational and administrative frame of reference. This is to say that attitudes about patients, associates, oneself, and one's profession are reflected in one's operational procedures and that other staff members and patients establish a frame of reference about occupational therapy on the basis of these attitudes.

Concepts concerning mental health processes or the therapeutic milieu are not exclusive of individual departmental

organization and function, but rather the success of such philosophies and methods is in great measure dependent on the extent to which they permeate all departmental functioning.

Recognition and acceptance of basic human needs are as vital to departmental administration and the staff members who are part of this organization as they are to patient programming. The success or value of any administrative procedure to a large extent may be measured by the degree to which it enhances the sense of integrity and worth of those who are involved.

The needs for acceptance, mutual dependency and sharing, a sense of individuality, and an opportunity to function as a productive, contributing member of one's group or society are as cardinal to staff as they are to patients.

Increased understanding of social systems in institutions produces a finer appreciation of the many administrative dilemmas. One problem resulting from the nature of most systems is the sense of powerlessness experienced by many within such a system. Bensman and Rosenberg [1] point out that a feeling of being powerless is fundamentally related to the structure of bureaucracy and that such a feeling may be greatly sharpened in systems where each job is systematically defined and where duties and privileges are clearly delineated. The inherent responsibility for patient welfare within a hospital and the complexities of treatment and well-developed status systems tend to perpetuate a sense of powerlessness in employees. Thus, it is difficult for individual members or groups to have any real sense of being able to

[1] Bensman, Joseph, and Rosenberg, Bernard: "The Meaning of Work in Bureaucratic Society," in *Identity and Anxiety: Survival of the Person in Mass Society*. Glencoe, Ill.: The Free Press, 1960.

effect change or influence the course of events. It is obvious that departmental administrative policies and procedures are influenced by such feelings but that they may also diminish such impressions.

Specialization in medicine and clearly delineated disciplines and departments in hospitals make it difficult for the therapist or worker to see beyond his specific function or task. Thus, a feeling of not being really involved in the total hospital or with the total patient care and treatment creates a sense of isolation and tends to produce fragmentation. Administrative policies and methods of organization may reinforce such feelings or more appropriately be directed toward integrative measures.

Man's status needs and how these influence all aspects of his functioning have been explored and discussed in sociologic studies. It would seem sufficient for discussion here to select one aspect of this complex phenomenon that seems to have particular significance with regard to administrative policies in occupational therapy. The relatively low status of occupational therapy in most hospitals creates several problems, which impinge on how an occupational therapy department may organize itself and administer its services. We have discussed how role expectations occur and are used in patient-therapist relationships, and it is important to recognize that the same process occurs among staff members. How one sees oneself and others influences how others may in turn perceive one and forms the basis of "role expectations." Within any continuing organization a certain set of expectations ultimately develops concerning the role and function of each group or person, and these tend to be perpetuated. How the occupational therapy department operates reflects not only how occupational therapists feel

about themselves but also either contributes to the perpetuation of a given role or influences a change in such role concepts.

A sense of inadequacy about one's low status may be evidenced in rigid, strict adherence to numerous rules and structure, which minimizes chances of exposure. While such administrative procedures guard against failure or exposing one's limitations, they also inhibit creative experimentation and make any alterations in role expectations unlikely.

Limited communication and interaction with others outside one's group tend to perpetuate an established position or set of values by inhibiting the learning and growth inherent in such interaction. Reliance on written referrals and progress notes may indicate a wariness about personal contact and serve to limit or guard against such interaction. The extent to which organizational or administrative policies inhibit or encourage a sharing and exchange of ideas and knowledge is in proportion to the perceived risk in such communication.

One of the more common ways of attempting to deal with the problems of status needs and identity is to associate oneself with an already established group within the existing hierarchy. For example, if the occupational therapist dresses like the nurse, perhaps some of the nurse's status and identification will become available. Likewise, a medical prescription may help to identify one with the medical process. Here again, administrative policies may either be directed primarily toward identification with other established groups or they may provide opportunities for exploring and developing a separate and vital identity.

These problems and many others are not unique to occupational therapy but are understandably more difficult

for a relatively new discipline striving toward professional recognition in an already established hierarchy. Attempts to put into practice more dynamic concepts necessitate departmental administration and organization that reach beyond the more conventional role definition of occupational therapy. One cannot devise a set of operating procedures that may be expected to work equally well in all settings. The decision about what may be implemented and how this can best be accomplished must be made on the basis of the uniqueness of a given situation. However, there are some general procedures that we feel do appreciably ease problems of administering a dynamic program of occupational therapy and contribute to the effectiveness of such programs.

The arrangement and structure of the occupational therapy room or area in which occupational therapy takes place do influence what occurs in this experience. The lack of organization or orderliness may well increase the patient's sense of fragmentation, disorganization, and confusion. On the other hand, meticulous routine and rigid arrangement may well inhibit freedom of expression and interaction.

If activities are to be used in correlation with patient needs and problems, it is important that each occupational therapy room contain a sufficient variety of activities to allow movement from one activity to another without interruption in either the therapist-patient relationship or group relationships. Separation of areas on the basis of activities, such as having a ceramics room or a wood-working room, makes it almost impossible to achieve the goals or the purposes as we have defined them. In addition, areas that are large and are shared by other occupational therapists and patient groups make the development of an interacting group or close interpersonal relationship unlikely.

Seemingly, over the years occupational therapy has come to be more and more associated with the use of arts and crafts, and by and large activities available to patients in most settings are limited to these. The scope of action experiences in occupational therapy is preserved by an education that places priority on the learning of crafts in preference to other activities. Furthermore, programs led by other professional groups tend to solidify this role definition. It is essential that the scope of action experiences in occupational therapy be broadened. This requires a departmental administration that understands the nature and purpose of occupational therapy as well as the issues involved in the delimiting of arts and crafts to this discipline. If one perceives occupational therapy as being primarily concerned with action and its meaning, one can appreciate the need for latitude in activities.

In addition, the nature of occupational therapy has been such that to many persons this experience has come to be almost synonymous with doing some "thing" or completing a project. Emphasis on an end product limits the extent of one's awareness of the process of action and the meaning of an activity. For example, persons have many times been concerned because patients and therapists are "not doing anything" and are "simply talking" or "being inactive." It is important to perceive and use as a catalytic agent any or all action or inactivity that occurs. Here again, administrative measures may do much to increase others' awareness of these values as well as support the occupational therapist in exploring them.

While most occupational therapy occurs in a room or area designated for this purpose, if one is limited to this area, opportunities for effective functioning are necessarily restricted. Movement into areas of the hospital where patients

live or come together for other purposes many times is of therapeutic benefit to the patient and contributes to the total hospital program.

If one agrees that the interpersonal relationship is a highly significant factor in treatment, procedures that will maximize opportunities for developing and sustaining such a relationship become important. It is of value to organize a department so that patients may be referred to an occupational therapist rather than to an area and that this relationship may be continued as long as the patient remains in occupational therapy. It is obvious that this is difficult and many times impossible in large institutions with constant movement of patients. However, it can be managed more frequently than one might assume, at least in some areas of a hospital. When this is not possible, the department should devise a transfer system of patients that will provide carry-over in treatment plans and goals. This may be done simply by a conference between the new and referring occupational therapist and an arrangement for the new therapist to meet with the patient before transfer.

The scheduling and selection of patients as well as the size of groups are issues that confront every administrator of an occupational therapy program. Here again, the nature of the hospital organization and its size will determine methods to some extent. Nevertheless, one needs to be aware of the value of scheduling individual patients on the basis of the therapist with whom they will work rather than as a group identified by a ward or building. Administrative policies must stem from sufficient pliability and integrity to permit flexibility in scheduling, establishing a meaningful selection of patients on an individual basis, and limiting the numbers of patients or size of groups appropriately.

Participation in the total aspect of patient care and treat-

ment is essential. Occupational therapy cannot remain isolated and expect to make any appreciable contribution to either patients or the hospital. It is essential that the occupational therapist become involved as an active, contributing participant in clinical staff conferences, patient meetings, program planning, etc. Administrators must recognize this, make it possible, and clearly expect this function from their staffs.

The administration of a department reflects the attitudes one has concerning one's profession and its members and determines the nature of staff morale. Decisions and the process of making decisions must be such that they enable the staff member and student to experience a sense of involvement and contribution, an awareness that he is perceived as a responsible, intelligent adult, capable of making decisions, working with others, and having a capacity to assume such responsibilities, and to experience consensual validation.

Opportunities for learning and growth, to see one's potential and to work toward realization of this potential, have a direct bearing on morale and thus on what one may contribute. In addition, an increased awareness of oneself enhances one's understanding of others and increases the effectiveness of one's functioning. Providing opportunities for this kind of experience is an essential part of departmental organization and function. Occupational therapists need to develop a better understanding of the nature and meaning of supervision in order that this may be used as an integral part of administration. Supervision in this sense does not refer to the routine checking of or concern with basic duties and responsibilities. It does constitute the development of a collaborative relationship between supervisor and student

or therapist wherein self-awareness may occur and be used to explore and understand what is going on between oneself and one's patient. In this area, the occupational therapist needs to borrow from the knowledge and experience of others who have developed and used these techniques, as in the training of the analyst and the psychiatric social worker.

In addition, departmental conferences for case presentations, for discussion of books and articles, and for exploration of any aspect of functioning provide excellent shared learning experiences that contribute greatly to morale and staff cohesiveness. When members of other professions are invited to participate, mutual respect and understanding are considerably enhanced.

Finally, opportunities must exist for exploration and experimentation. Policies and philosophies must not only be flexible enough to permit creative thinking but must also actively stimulate and support such an endeavor.

These concepts and others to which we have referred throughout this work are some of the significant factors that make it possible for each individual staff member to meet obligations to patients and to himself. The purpose of administration is to make possible the ultimate functioning of each individual within an organization in order that the purpose of such an organization may be realized.

REFERENCES

BENSMAN, JOSEPH, and ROSENBERG, BERNARD: "The Meaning of Work in Bureaucratic Society," in *Identity and Anxiety: Survival of the Person in Mass Society*. Glencoe, Ill.: The Free Press, 1960.

CUMMING, ELAINE, CLANCY, L. W., and CUMMING, JOHN: "Improving Patient Care through Organization Changes in the Mental Hospital," *Psychiatry*, Vol. 19, No. 3, 1956.

DUNHAM, WARREN H., and WINBERG, KIRSON S.: *Culture of the State Mental Hospital.* New York: Robert Brunner & Co., 1960.

FOLLETT, MARY PARKER: *Dynamic Administration.* Bath, England: Management Publications Trust, 1951.

KOLB, HARRY D.: "Creating an Organizational 'Atmosphere' for Improved Communication," *Personnel,* Vol. 3, No. 2, 1954.

MAIER, NORMAN R. F.: *Principles of Human Relations.* New York: John Wiley & Sons, Inc., 1952.

WALLER, WILLARD: "What Does Teaching Do To Teachers," in *Anxiety and Identity: Survival of the Person in Mass Society.* Glencoe, Ill.: The Free Press, 1960.

ZETEL, E. R.: "The Dynamic Basis of Supervision," *Social Case Work,* Vol. 34, No. 4, 1953.

Bibliography

PSYCHIATRIC THEORY

APPLEBY, LAWRENCE, SCHER, JORDAN, and CUMMING, JOHN: *Chronic Schizophrenia.* Glencoe, Ill.: The Free Press, 1959.

AUERBACK, ALFRED (ed.): *Schizophrenia, An Integrated Approach.* New York: The Ronald Press Co., 1959.

AUSUBEL, DAVID F.: *Theory and Problems of Child Development.* New York: Grune & Stratton, Inc., 1958.

AYRES, A. JEAN: "Development of the Body Scheme in Children," *Am. J. Occupat. Therapy,* Vol. 15, No. 3, 1961.

BELLAK, LEOPOLD: *Schizophrenia: A Review of the Syndrome.* New York: Logos Press, 1958.

BENDA, CLEMENS E.: *The Image of Love.* Glencoe, Ill.: The Free Press, 1962.

BRUCH, HILDA: "Falsification of Bodily Needs and Body Concept in Schizophrenia," *Arch. Gen. Psychiat.,* Vol. 6, No. 1, 1961.

BURNHAM, DONALD L.: "Identity Definition and Role Demand in the Hospital Careers of Schizophrenic Patients," *Psychiatry,* Vol. 24, Supplement to No. 2, 1961.

BURTON, ARTHUR, and ADKINS, JOEL: "Perceived Size of Self-Image Body Parts in Schizophrenia," *Arch. Gen. Psychiat.,* Vol. 5, No. 2, 1961.

DARWIN, CHARLES ROBERT: *The Expression of Emotions in Man and Animals.* New York: Philosophical Library, Inc., 1953.

EHRENWALD, JAN: "The Symbiotic Matrix of Paranoid Delusions," *Am. J. Psychoanalysis,* Vol. 20, No. 1, 1960.

ENGLISH, O. S.: *Personality Manifestations in Psychosomatic Illness.* New York: Edward Stern & Co., Inc., 1953.

EYSENCK, H. J., GRANGER, GEORGE W., and BRENGELMANN, J. C.: *Perceptual Processes and Mental Illness.* New York: Basic Books, Inc., 1958.

FINCH, STUART M.: *Fundamentals of Child Psychiatry.* New York: W. W. Norton & Co., Inc., 1960.

FOOTE, NELSON L., and COTRELL, LEONARD S.: *Identity and Interpersonal Competence.* Chicago: University of Chicago Press, 1957.

FREEMAN, THOMAS, CAMERON, JOHN L., and MC GHIE, ANDREW: *Chronic Schizophrenia.* New York: International Universities Press, Inc., 1958.

GLASSER, WILLIAM: *Mental Health or Mental Illness.* New York: Harper & Bros., 1960.

GROZINGER, WOLFGANG: *Scribbling, Drawing, Painting (Their Role in Child Development).* New York: Frederick A. Praeger, 1955.

JACKSON, DON D. (ed.): *The Etiology of Schizophrenia.* New York: Basic Books, Inc., 1960.

JAFFE, JOSEPH: "Language of the Dyad," *Psychiatry,* Vol. 21, No. 3, 1958.

JOSSELYN, IRENE: *Psychological Development of Children.* New York: Family Service Association of America, 1948.

KOHN, MELVIN L., and CLAUSEN, JOHN: "Social Isolation and Schizophrenia," *Am. Sociolog. Rev.,* Vol. 20, No. 3, 1955.

LAWN, ELIZABETH CALVERLEY: "Symbols for Psychiatric Occupational Therapy, A Preliminary Report of Their Practical Use," *Am. J. Occupat. Therapy,* Vol. 16, No. 3, 1962.

LEDWITH, HETTIE: *Rorschach Responses of Elementary School Children.* New York: Robert Brunner & Co., 1961.

LENNARD, HENRY L., and BERNSTEIN, ARNOLD: *The Anatomy of Psychotherapy.* New York: Columbia University Press, 1960.

LEVY, DAVID M.: "The 'Act' as an Operational Concept in Psychodynamics," *Psychosom. Med.,* Vol. 24, No. 1, 1962.

LIMENTANI, DAVIDE: "Symbiotic Identification in Schizophrenia," *Psychiatry,* Vol. 19, No. 3, 1956.

LOEWENSTEIN, RUDOLF (ed.): *Drives, Affects, Behavior.* New York: International Universities Press, Inc., 1953.

LORAND, SANDOR, and SCHNEER, HENRY L.: *Adolescents: Psychoanalytic Perceptives.* New York: Paul Hoeber Co., 1961.

MC ABLEY, W. F.: *The Concept of Schizophrenia.* New York: Philosophical Library, Inc., 1954.

MURPHY, LOIS: *Personality in Young Children.* New York: Basic Books, Inc., 1961.

PACKARD, P. M.: *I Could a Tale Unfold.* New York: Robert Brunner & Co., 1961.

PARKER, BEULAH: *My Language Is Me.* New York: Robert Brunner & Co., 1961.

PECK, JEAN BLACKMAN: "Development and Management of Transference," *Am. J. Occupat. Therapy,* Vol. 16, No. 2, 1962.

PERCY, WALKER: "The Symbolic Structure of Interpersonal Process," *Psychiatry,* Vol. 24, No. 1, 1961.

READ, KATHERINE H.: *The Nursery School; A Human Relations Laboratory.* Philadelphia: W. B. Saunders Co., 1955.

REDL, FRITZ, and WINEMAN, DAVID: *The Aggressive Child.* Glencoe, Ill.: The Free Press, 1957.

REUSCH, JURGEN: *Therapeutic Communication.* New York: W. W. Norton & Co., Inc., 1961.

RUBINFINE, DAVID L.: "Perception, Reality Testing, and Symbolism," in *Psychoanalytic Study of the Child,* Vol. 16. New York: International Universities Press, Inc., 1961.

RUBINS, JACK L.: "The Self-Concept, Identity, and Alienation from Self," *Am. J. Psychoanalysis,* Vol. 21, No. 2, 1961.

SCHWARTZ, DONALD: "Some Suggestions for a Unitary Formulation of the Manic-Depressive Reactions," *Psychiatry,* Vol. 24, No. 3, 1961.

SHAPIRO, DAVID: "Aspects of Obsessive-Compulsive Style," *Psychiatry,* Vol. 25, No. 1, 1962.

STEINFIELD, JULIUS I.: *A New Approach to Schizophrenia.* New York: Merlin Press, 1956.

SULLIVAN, HARRY STACK: *The Interpersonal Theory of Psychiatry.* New York: W. W. Norton & Co., Inc., 1953.

SZALITA, ALBERTA B.: "Regression and Perception in Psychotic States," *Psychiatry,* Vol. 21, No. 1, 1958.

THORP, LOUIS P.: *The Psychology of Mental Health.* New York: The Ronald Press Co., 1960.

WEBLIN, JOHN: "Communication and Schizophrenic Behavior," *Family Process,* Vol. 1, No. 1, 1962.

WERTHEIMER, MAX: *Productive Thinking.* New York: Harper & Bros., 1959.

WESTON, DONALD L.: "The Dimensions of Crafts," *Am. J. Occupat. Therapy*, Vol. 15, No. 1, 1961.

WHORF, BENJAMIN LEE: *Language Thought and Reality: Selected Writings*. Evanston, Ill.: John Willy, Inc., 1956.

WILL, OTTO ALLEN, JR.: "Human Relatedness and the Schizophrenic Reaction," *Psychiatry*, Vol. 22, No. 3, 1959.

———: "Paranoid Development and the Concept of Self," *Psychiatry*, Vol. 24, Supplement to No. 2, 1961.

ZUCKER, LUISE: *Ego Structure in Paranoid Schizophrenia*. Springfield, Ill.: Charles C Thomas, 1958.

SOCIOLOGIC CONCEPTS

ALLPORT, GORDON W.: *Personality and Social Encounter*. New York: Robert Brunner & Co., 1960.

BENNE, KENNETH D.: *A Conception of Authority*. New York: Teachers College, Columbia University, 1943.

BENNE, KENNETH D., and SWANSON, G. E.: "Values and the Social Scientist," *J. Social Issues*, Vol. 6, No. 4, 1950.

CHASE, STUART: *Roads to Agreement*. New York: Harper & Bros., 1951.

COLEMAN, JAMES S.: *The Adolescent Society*. Glencoe, Ill.: The Free Press, 1961.

COX, F. N.: "Sociometric Status and Individual Adjustment before and after Play Therapy," *J. Abnormal & Social Psychol.*, Vol. 48, No. 3, 1953.

CUMMING, ELAINE, and CUMMING, JOHN: "The Locus of Power in a Large Mental Hospital," *Psychiatry*, Vol. 19, No. 4, 1956.

ETZIONI, AMITAI: "Interpersonal and Structural Factors in the Study of Mental Hospitals," *Psychiatry*, Vol. 23, No. 1, 1960.

HENRY, JULES: "The Formal Social Structure of a Psychiatric Hospital," *Psychiatry*, Vol. 17, No. 2, 1954.

JAQUES, ELLIOTT: "On the Dynamics of Social Structure," *Human Relations*, Vol. 6, No. 1, 1953.

LEIGHTON, ALEXANDER H. (ed.): *Explorations in Social Psychiatry*. New York: Basic Books, Inc., 1958.

LEWIN, KURT: *Field Theory in Social Science*. New York: Harper & Bros., 1951.

———: *Resolving Social Conflicts*. New York: Harper & Bros., 1948.

MILLER, JAMES GRIER (ed.): *Experiments in Social Process.* New York: McGraw-Hill Book Co., Inc., 1950.

MUENSTERBERGER, WARNER, and AXELRAD, SIDNEY (eds.): *Psychoanalysis and the Social Sciences,* Vol. 5. New York: International Universities Press, Inc., 1958.

MURDOCK, GEORGE P.: *Social Structure.* New York: The Macmillan Co., 1949.

REDICH, FREDERICK C., HOLLINGSHEAD, AUGUST B., and BELLIS, ELIZABETH: "Social Class Differences in Attitudes toward Psychiatry," *Am. J. Orthopsychiat.,* Vol. 25, No. 1, 1955.

SIMMONS, LEO W., and WOLF, HAROLD G.: *Social Science in Medicine.* New York: Russell Sage Foundation, 1955.

STANTON, ALFRED H., and SCHWARTZ, MORRIS S.: "Medical Opinion and the Social Context in the Mental Hospital," *Psychiatry,* Vol. 12, No. 3, 1949.

———: *The Mental Hospital: A Study in Institutional Participation in Psychiatric Illness and Treatment.* New York: Basic Books, Inc., 1954.

———: "Observations on Dissociation as Social Participation," *Psychiatry,* Vol. 12, No. 4, 1949.

———: "Psychiatric Theory and Institutional Context," *Psychiatry,* Vol. 17, No. 1, 1954.

STEIN, MAURICE, VIDICH, ARTHUR, and WHITE, MANNING: *Identity and Anxiety—Survival of the Person in Mass Society.* Glencoe, Ill.: The Free Press, 1960.

SWANSON, G. E., NEWCOMB, T. M., HARTLY, E. L., *et al.: Readings in Social Psychology.* New York: Henry Holt & Co., 1952.

Symposium on Preventive and Social Psychiatry. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1959.

TREATMENT TECHNIQUES

ALT, HERSHEL: *Residential Treatment of the Disturbed Child.* New York: International Universities Press, Inc., 1960.

ARIETI, SILVANO: "Psychotherapy of Schizophrenia," *Arch. Gen. Psychiat.,* Vol. 6, No. 2, 1962.

———: "Schizophrenia: Other Aspects; Psychotherapy," in *American Handbook of Psychiatry,* Vol. 1. New York: Basic Books, Inc., 1959.

AZIMA, H., VISPO, R. H., and MC KENNA, R.: "Anaclitic Therapy Induced by Drugs," *Comprehensive Psychiat.*, Vol. 2, No. 5, 1961.

AZIMA, H., WITTKOWER, E. D., and LATENDRESSE, J.: "Object Relations Therapy in Schizophrenic States," *Am. J. Psychiat.*, Vol. 115, No. 1, 1958.

BALINT, MICHAEL: "The Regressed Patient and His Analyst," *Psychiatry*, Vol. 23, No. 3, 1960.

BETTLEHEIM, BRUNO: *Love Is Not Enough.* New York: Basic Books, Inc., 1950.

BIRD, B.: *Talking with Patients.* Philadelphia: J. B. Lippincott Co., 1955.

CONTE, WILLIAM R.: "The Occupational Therapist as a Therapist," *Am. J. Occupat. Therapy*, Vol. 14, No. 1, 1960.

FROMM-REICHMAN, FRIEDA: "Basic Problems in the Psychotherapy of Schizophrenia," *Psychiatry*, Vol. 21, No. 1, 1958.

FROMM-REICHMAN, FRIEDA, and MORENO, J. L. (eds.): *Progress in Psychotherapy.* New York: Grune & Stratton, Inc., 1956.

HALEY, JAY: "Control in Psychotherapy with Schizophrenics," *Arch. Gen. Psychiat.*, Vol. 5, No. 4, 1961.

HILL, LEWIS B.: *Psychotherapeutic Intervention in Schizophrenia.* Chicago: University of Chicago Press, 1955.

JACKSON, DON D., RISKIN, JULES, and SATIR, VIRGINIA: "A Method of Analysis of a Family Interview," *Arch. Gen. Psychiat.*, Vol. 5, No. 4, 1961.

JOSSELYN, IRENE: *The Happy Child.* New York: Random House, 1955.

KLAPMAN, J. W.: *Group Psychotherapy: Theory and Practice*, 2nd ed. New York: Grune & Stratton, Inc., 1959.

KLEIN, MELANIE: *The Narrative of a Child Analysis.* New York: Basic Books, Inc., 1961.

LENNARD, H. L., and BERNSTEIN, A.: *The Anatomy of Psychotherapy.* New York: Columbia University Press, 1960.

LEVINE, D., MARKS, H., and HALL, R.: "Differential Effects of Factors in an Activity Therapy Program," *Am. J. Psychiat.*, Vol. 114, No. 6, 1957.

LEWIN, BERTRAM D.: *The Psychoanalysis of Elation.* New York: W. W. Norton & Co., Inc., 1950.

MASSERMAN, JULES: *Practice of Dynamic Psychiatry.* New York: Robert Brunner & Co., 1955.

MOUSTAKAS, CLARK E.: *Children in Play Therapy.* New York: McGraw-Hill Book Co., Inc., 1953.

NAUMBERG, MARGARET: *Schizophrenic Art: Its Meaning in Psychotherapy.* New York: Grune & Stratton, Inc., 1950.

———: *Studies of the Free Art Expression of Behavior Problem Children and Adolescents as a Means of Diagnosis and Therapy.* New York: Robert Brunner & Co., 1954.

NEILL, A. S.: *Summerhill.* New York: Hart Publishing Co., Inc., 1960.

REUSCH, JURGEN: "Nonverbal Language and Therapy," *Psychiatry,* Vol. 18, No. 4, 1955.

ROBINSON, RUTH A., ARONSON, JASON A., and BOLGAR, STEVEN: "The Use of Self in Occupational Therapy," *Am. J. Occupat. Therapy,* Vol. 14, No. 6, 1960.

RODGERS, C. R., and DYMOND, R. (eds.): *Psychotherapy and Personality Change.* Chicago: University of Chicago Press, 1954.

ROSEN, ELIZABETH: *Dance in Psychotherapy.* New York: Teachers College, Columbia University, 1957.

SALZMAN, LEON: "Paranoid State—Theory and Therapy," *Arch. Gen. Psychiat.,* Vol. 2, No. 6, 1960.

SECHEHAYE, MARGUERITE: *A New Psychotherapy in Schizophrenia.* New York: Grune & Stratton, Inc., 1956.

———: *Symbolic Realization.* New York: International Universities Press, Inc., 1951.

SELZER, MELVIN L.: "The Use of First Names in Psychotherapy," *Arch. Gen. Psychiat.,* Vol. 3, No. 3, 1960.

STANTON, ALFRED: "Milieu Therapy and the Development of Insight," *Psychiatry,* Vol. 24, Supplement to No. 2, 1961.

STEISEL, I. M., WEILAND, I. H., DENNY, J. R., SMITH, K., and CHAIKEN, N.: "Measuring Interaction in Nonverbal Children," *Am. J. Orthopsychiat.,* Vol. 30, No. 3, 1960.

SULLIVAN, HARRY STACK.: *The Psychiatric Interview.* New York: W. W. Norton & Co., Inc., 1954.

THIBAUT, JOHN W., and COULES, JOHN: "The Role of Communication in the Reduction of Interpersonal Hostility," *J. Abnormal & Social Psychol.,* Vol. 47, No. 4, 1952.

WEIGERT, EDITH: "Problems of Communication between Doctor and Patient in Psychotherapy," *Psychiatry,* Vol. 21, No. 3, 1958.

WOLBERG, LEWIS R.: *The Technique of Psychotherapy.* New York: Grune & Stratton, Inc., 1954.

GROUP THERAPY

BACH, GEORGE ROBERT: *Intensive Group Therapy.* New York: The Ronald Press Co., 1954.

BLOCK, STANLEY: "Multi-leadership as a Teaching and Therapeutic Tool in Group Psychotherapy," *Comprehensive Psychiat.*, Vol. 2, No. 4, 1961.

BRUGGER, THOMAS, CAESAR, GEORGE, FRANK, ALVIN, and MARTY, SAMUEL: "Peer Supervision as a Method of Learning Psychotherapy," *Comprehensive Psychiat.*, Vol. 3, No. 1, 1962.

FRAMO, JAMES L.: "The Theory of the Technique of Family Treatment of Schizophrenia," *Family Process*, Vol. 1, No. 1, 1962.

FREEMAN, H., and KING, C.: "The Role of Visitors in Activity Group Therapy," *Internat. J. Group Psychotherapy*, Vol. 7, No. 3, 1957.

GELLER, JOSEPH J.: "Parataxic Distortions in the Initial Stages of Group Relationships," *Internat. J. Group Psychotherapy*, Vol. 12, No. 1, 1962.

GRALNICK, ALEXANDER: "Family Psychotherapy: General and Specific Considerations," *Am. J. Orthopsychiat.*, Vol. 32, No. 3, 1962.

KNOBLOCH, F.: "Interaction Process Analysis of Two Psychotherapy Groups," *Internat. J. Group Psychotherapy*, Vol. 10, No. 4, 1960.

KONOPKA, GISELA: *Group Work in the Institution.* New York: Association Press, 1954.

———: "Knowledge and Skill of the Group Therapist," *Am. J. Orthopsychiat.*, Vol. 19, No. 1, 1949.

MARGOLIS, LILLIAN: "Criteria for Selection of Children for Activity Group Therapy," *Smith College Studies in Social Work*, Vol. 14, 1946.

POWDERMAKER, FLORENCE, and FRANK, JEROME D.: *Group Psychotherapy.* Cambridge, Mass.: Harvard University Press, 1953.

ROSENTHAL, L., and NAGELBERG, L.: "Limitations of Activity Group Therapy," *Internat. J. Group Psychotherapy*, Vol. 6, No. 2, 1956.

ROSENTHAL, LESLIE: "Counter-transference in Activity Group Therapy," *Internat. J. Group Psychotherapy*, Vol. 6, No. 2, 1956.

SCHEIDLINGER, SAUL: "Activity Group Therapy with Primary Behavior Disorders in Children," in Slavson, S. R. (ed.): *The Practice of Group Therapy.* New York: International Universities Press, Inc., 1947.

SCHIFFER, MORTIMER: "Trips as a Treatment Tool in Activity Group Therapy," *Internat. J. Group Psychotherapy*, Vol. 2, No. 3, 1952.

SLAVSON, S. R.: "Criteria for Selection and Rejection of Patient for Various Types of Group Therapy," *Internat. J. Group Psychotherapy,* Vol. 4, No. 1, 1955.

———: "Differential Dynamics of Activity and Interview Group Therapy," *Am. J. Orthopsychiat.,* Vol. 17, No. 2, 1947.

———: *Introduction to Group Therapy.* New York: International Universities Press, Inc., 1954.

SLAVSON, S. R. (ed.): *The Practice of Group Therapy.* New York: International Universities Press, Inc., 1947.

STOCK, DOROTHY, and LIEBERMAN, MORTON A.: "Methodological Issues in the Assessment of Total-group Phenomena in Group Therapy," *Internat. J. Group Psychotherapy,* Vol. 12, No. 3, 1962.

WENDER, LOUIS, and STEIN, AARON: "The Utilization of Group Psychotherapy in the Social Integration of Patients: An Extension of the Method of Self-governing Patient Groups," *Internat. J. Group Psychotherapy,* Vol. 3, No. 2, 1953.

ZIMMERMAN, DAVID: "Application of Group Psychotherapy to the Teaching of Dynamic Psychiatry and Understanding Student Resistances," *Internat. J. Group Psychotherapy,* Vol. 10, No. 1, 1960.

GROUP DYNAMICS

BONNEE, HUBERT: *Group Dynamics; Principles and Applications.* New York: The Ronald Press Co., 1959.

BRADFORD, LELAND P., and FRENCH, JOHN R.: "The Dynamics of the Discussion Group," *J. Social Issues,* Vol. 4, No. 2, 1948.

CARTWRIGHT, DORWIN, and ZANDER, ALVIN (eds.): *Group Dynamics Research and Theory.* Evanston, Ill.: Row, Peterson & Co., 1960.

GOODRICH, WELLS D., MAZER, JUNE, and STOCK, BETTY: "Fostering the Involvement of the Psychiatric Patient in Group Activities," *Psychiatry,* Vol. 21, No. 3, 1958.

HARE, PAUL A., BORGATTA, EDGAR F., and BALES, ROBERT F.: *Small Groups; Studies in Social Interaction.* New York: Alfred A. Knopf, Inc., 1955.

HERBERT, ELEONORE L.: "The Use of Group Techniques in the Training of Teachers," *Human Relations,* Vol. 14, No. 3, 1961.

JENKINS, R. L., and CURRAN, FRANK J.: "The Evolution and Persistence of Groups in a Psychiatric Observation Ward," *J. Social Psychol.,* Vol. 12, No. 4, 1940.

JUDD, JADWIGA, KOHN, REGINA E., and SCHULMAN, GERDA L.: "Group Supervision: A Vehicle for Professional Development," *Social Work,* Vol. 7, No. 1, 1962.

LERNER, HARRY R., and KELMAN, HERBERT C. (eds.): "Group Methods in Psychotherapy, Social Work, and Adult Education," *J. Social Issues,* Vol. 8, No. 2, 1952.

LINDT, HENDRICK, and PENNAL, HUGH A.: "On the Defensive Quality of Groups: A Commentary on the Use of the Group as a Tool to Control Reality," *Internat. J. Group Psychotherapy,* Vol. 12, No. 2, 1962.

LYLE, JACK: "Communication, Group Atmosphere, Productivity, and Morale in Small Task Groups," *Human Relations,* Vol. 14, No. 4, 1961.

MANN, JAMES: "Psychoanalytic Observations Regarding Conformity in Groups," *Internat. J. Group Psychotherapy,* Vol. 12, No. 1, 1962.

OVERSTREET, HARRY ALLEN: *The Great Enterprise.* New York: W. W. Norton & Co., Inc., 1952.

REDL, FRITZ, and WATTENBERG, WILLIAM W.: *Mental Hygiene in Teaching.* (Group training problems in an educational setting.) New York: Harcourt, Brace & Co., 1959.

SLAVSON, S. R.: "When Is a 'Therapy Group' Not a Therapy Group?" *Internat. J. Group Psychotherapy,* Vol. 10, No. 1, 1960.

SULLIVAN, DOROTHEA F. (ed.): *Readings in Group Work.* New York: Association Press, 1952.

WECHSLER, IRVING R., and REISEL, JEROME: *Inside a Sensitivity Training Group.* Los Angeles: Institute of Industrial Relations, University of California, 1960.

ZANDER, ALVIN: "Group Membership and Individual Security," *Human Relations,* Vol. 11, No. 2, 1958.

THE HOSPITAL COMMUNITY

BAND, RAYMOND I., and BRODY, EUGENE B.: "Human Elements of the Therapeutic Community," *Arch. Gen. Psychiat.,* Vol. 6, No. 4, 1962.

BARTON, WALTER E.: "Observations on the Therapeutic Aspects of Administration in Public Mental Hospitals," *Am. J. Psychiat.,* Vol. 114, No. 6, 1957.

DEANE, WILLIAM N.: "The Reactions of a Nonpatient to a Stay on a Mental Hospital Ward," *Psychiatry,* Vol. 24, No. 1, 1961.

DELANGE, WALTER H.: "Conceptions of Patient Role by Patients and Staff in a State Mental Hospital," *Comprehensive Psychiat.*, Vol. 3, 1962.

DEVEREUX, GEORGE: "The Social Structure of the Schizophrenic Ward and Its Therapeutic Fitness," *J. Clin. Psychopathol.*, Vol. 6, No. 3, 1944.

GOLDBERG, ARNOLD, OFFER, DANIEL, and SCHATZMAN, LEONARD: "The Role of the Uniform in a Psychiatric Hospital," *Comprehensive Psychiat.*, Vol. 2, No. 1, 1961.

GREENBLATT, MILTON (ed.): *Mental Patients in Transition.* Springfield, Ill.: Charles C Thomas, 1961.

HYDE, ROBERT, and SOLOMON, HARRY C.: "Clinical Management of Psychiatric Hospitals," *Connecticut State M.J.*, Vol. 15, No. 2, 1954.

JONES, MAXWELL: "The Concept of a Therapeutic Community," *Am. J. Psychiat.*, Vol. 112, No. 8, 1956.

———: "The Treatment of Character Disorders in a Therapeutic Community," *Bull. World Federation of Ment. Health*, Vol. 6, No. 2, 1954.

KRAUS, P. STEFAN: "Considerations and Problems of Ward Care for Schizophrenic Patients; Formulations of a Total Responsibility Program," *Psychiatry*, Vol. 17, No. 3, 1954.

———: "Ward Care for Schizophrenic Patients," *Psychiatry*, Vol. 17, No. 3, 1954.

LICHTENBERG, JOSEPH D.: "A Study of the Changing Role of the Psychiatrist in the State Hospital," *Psychiat. Quart.*, Vol. 28, No. 1, 1954.

MCCULLOUGH, W. E.: "Report of an Integrated Therapeutic Program; A Three Year Ward Experiment," *Psychiat. Quart.*, Vol. 29, No. 2, 1955.

MAIN, T. F.: "The Hospital as a Therapeutic Institution," *Bull. Menninger Clin.*, Vol. 10, No. 3, 1946.

MIDDLETON, JOHN: "Prejudices and Opinions of Mental Hospital Employees Regarding Mental Illness," *Am. J. Psychiat.*, Vol. 110, No. 2, 1953.

MORIMOTO, FRANÇOISE R.: "The Socializing Role of Psychiatric Ward Personnel," *Am. J. Nursing*, Vol. 54, No. 1, 1954.

MORIMOTO, FRANÇOISE R., and GREENBLATT, MILTON: "Personnel Awareness of Patients' Socializing Capacity," *Am. J. Psychiat.*, Vol. 110, No. 6, 1953.

RABIN, A. I.: "Social Contacts of Psychiatric Patients: Some Preliminary Observations," *Psychiat. Quart. Supplement*, Vol. 19, Part 2, 1945.

REES, T. P., and GLATT, M. N.: "The Organization of a Mental Hospital on the Basis of Group Participation," *Internat. J. Group Psychotherapy*, Vol. 5, No. 3, 1955.

SCHWARTZ, CHARLOTTE G., SCHWARTZ, MORRIS S., and STANTON, ALFRED H.: "A Study of Need Fulfillment on a Mental Hospital Ward," *Psychiatry*, Vol. 14, No. 2, 1951.

TUDOR, GWEN E.: "A Sociopsychiatric Nursing Approach to Intervention in a Problem of Mutual Withdrawal on a Mental Hospital Ward," *Psychiatry*, Vol. 15, No. 2, 1952.

VON MERING, OTTO, and KING, STANLEY H.: *Remotivating the Mental Patient*. New York: Russell Sage Foundation, 1957.

REHABILITATION

ADAMS, ANNE, MALLINSON, J., and GREENLAND, CYRIL: "Measuring Remotivation," *Psychiatry*, Vol. 25, No. 2, 1962.

ANDERSON, WAYNE, and KUNCE, JOSEPH: "Stresses of Discharge for the Mental Patient," *J. Rehabilitation*, Vol. 28, No. 3, 1962.

BELLAK, L., and BLACK, B. J.: "The Rehabilitation of Psychotics in the Community," *Am. J. Orthopsychiat.*, Vol. 30, No. 2, 1960.

BOAG, T. J.: "Further Developments in the Day Hospital," *Am. J. Psychiat.*, Vol. 116, No. 9, 1960.

BOLIN, B., and SCOTT, D.: "Patient Industry and the Workers' Attitude towards Their Jobs," *Am. J. Psychiat.*, Vol. 115, No. 3, 1958.

BRINKMAN, GERVASE: "The Philosophy of Work as Developed in International Correctional Congresses," *J. Social Therapy*, Vol. 7, No. 3, 1961.

BROOKS, GEORGE W.: "Rehabilitation of Hospitalized Chronic Schizophrenic Patients," in Appleby, Lawrence, Scher, Jordan, and Cumming, John (eds.): *Chronic Schizophrenia*. Glencoe, Ill.: The Free Press, 1960.

CONTE, W., OTERO, M., and GLADFELTER, J.: "Effects of Occupational Therapy on Chronic Schizophrenic Patients," in *The Scientific Papers of the One Hundred and Sixteenth Annual Meeting of American Psychiatric Association*. Washington, D.C.: American Psychiatric Association, 1960.

EVANS, ANNE S., BALLARD, DEXTER M., JR., and SOLOMON, MAIDA H.: "The Family as a Potential Resource in the Rehabilitation of the Chronic Schizophrenic Patient: A Study of 60 Patients and Their Families," *Am. J. Psychiat.*, Vol. 117, No. 12, 1961.

FRIEDMAN, T., ROLFE, P., and PERRY, S.: "Home Treatment of Psychiatric Patients," *Am. J. Psychiat.*, Vol. 116, No. 9, 1960.

GORDON, HIRAM L., and GROTH, CLARENCE: "Mental Patients Wanting to Stay in the Hospital," *Arch. Gen. Psychiat.*, Vol. 4, No. 2, 1961.

GREENBLATT, M., and SIMON B.: *Rehabilitation of the Mentally Ill.* Washington, D.C.: American Association for the Advancement of Science, 1959.

HOWARD, BEDE F.: "An Optimistic Report on Total Rehabilitation Potential of Chronic Schizophrenics," *Arch. Gen. Psychiat.*, Vol. 3, No. 4, 1960.

JONES, M., and RAPOPORT, R.: "Psychiatric Rehabilitation," in *Year Book of Education.* London: Evans Bros., Ltd., 1955.

LANDY, DAVID, and SINGER, SARA E.: "The Social Organization and Culture of a Club for Former Mental Patients," *Human Relations,* Vol. 14, No. 1, 1961.

Occupational Therapy as a Link in Rehabilitation. Proceedings of the Second International Congress. World Federation of Occupational Therapists, New York, 1959.

OVESEY, LIONEL: "Fear of Vocational Success," *Arch. Gen. Psychiat.*, Vol. 7, No. 2, 1962.

ROCKMORE, M., and MARSH, E.: "Community Planning as a Support to Treatment," *Am. J. Psychiat.*, Vol. 116, No. 8, 1960.

SCHWARTZ, CHARLOTTE G.: "Rehabilitation of Mental Hospital Patients," Public Health Monograph No. 17, Publication No. 297, U.S. Public Health Service. Washington, D.C.: Government Printing Office.

SIMON, B.: "New Trends in Rehabilitation," in *Progress in Psychotherapy.* New York: Grune & Stratton, Inc., 1959.

TOURNEY, G., *et al.*: "The Effect of Resocialization Techniques in Chronic Schizophrenic Patients," *Am. J. Psychiat.*, Vol. 116, No. 11, 1960.

WHEAT, W. D., and SLAUGHTER, REGINA: "Coordinated Rehabilitation Programming for Chronic Psychiatric Patients," *J. Rehabilitation,* Vol. 27, No. 3, 1961.

MISCELLANEOUS

ANDREWS, KENNETH R.: *The Case Method of Teaching Human Relations and Administration: An Interim Statement.* Cambridge, Mass.: Harvard University Press, 1953.

BROWN, MARTHA M., and FOWLER, GRACE R.: *Psychodynamic Nursing.* Philadelphia: W. B. Saunders Co., 1954.

BURKE, RICHARD L., and BENNIS, WARREN G.: "Changes in Perception of Self and Others during Human Relations Training," *Human Relations,* Vol. 14, No. 2, 1961.

CONNERY, M. F.: "Problems in Teaching the Team Concept," *J. Psychiat. Social Work,* Vol. 21, No. 2, 1951.

DEVEREUX, GEORGE: *Therapeutic Education; Its Theoretical Basis and Practice.* New York: Harper & Bros., 1956.

ELLIS, MADELAINE, and BACHRACH, ARTHUR J.: "Psychiatric Occupational Therapy: Some Aspects of Roles and Functions," *Am. J. Psychiat.,* Vol. 115, No. 4, 1958.

HOLT, ROBERT R.: "Personality Growth in Psychiatric Residents," *Arch. Gen. Psychiat.,* Vol. 81, No. 2, 1959.

KEY, W.: *Project 52: A Study in Adjunctive Therapies Coordination.* Topeka, Kans.: Washburn University, 1958.

KNEPLER, ABRAHAM E.: "Role Playing in Education—Some Problems in Its Use," *Group Therapy,* Vol. 12, No. 1, 1959.

MODLIN, H. C., and FARIS, M.: "Follow-up Study of Psychiatric Team Functioning," *Bull. Menninger Clin.,* Vol. 18, No. 6, 1954.

NATHANSON, THERESA: "Self Awareness in the Educative Process," *Social Work,* Vol. 7, No. 2, 1962.

OFFER, DANIEL, and STINE, DIANE: "Function of Music in Spontaneous Art Productions," *Arch. Gen. Psychiat.,* Vol. 3, No. 5, 1960.

PIDOLSKY, EDWARD: *Music Therapy.* New York: Philosophical Library, Inc., 1954.

Psychiatric Formulations. The Objectives and Functions of Occupational Therapy. New York: American Occupational Therapy Association, 1958.

REILLY, MARY: "Occupational Therapy Can Be One of the Great Ideas of 20th Century Medicine," *Am. J. Occupat. Therapy,* Vol. 16, No. 1, 1962.

SCHIFFER, MORTIMER: "The Use of the Seminar in Training Teachers and Counselors as Leaders of Therapeutic Play Groups for Maladjusted Children," *Am. J. Orthopsychiat.,* Vol. 30, No. 1, 1960.

THELEN, HERBERT A.: "Educational Dynamics; Theory and Research," *J. Social Issues,* Vol. 6, No. 2, 1950.

TOWLE, CHARLOTTE: *The Learner in Education for the Professions: As Seen in Education for Social Work.* Chicago: University of Chicago Press, 1954.

WEST, WILMA L. (ed.): *Changing Concepts and Practices in Psychiatric Occupational Therapy.* New York: American Occupational Therapy Association, 1959.

Index

Index